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ABSTRACT

Largely descriptive, this final report of the Frontier Nursing Service (FNS) chronicles development and implementation of a Family Nurse Practitioner (PRIMEX) training program in a rural area from 1972-76. Centered in Leslie County, Kentucky, this project was one of seven PRIMEX programs in the nation; accomplishments in all of the projects far exceeded original goals. This report covers the FNS program's evaluation of primary care training and service both as to accessibility and effectiveness in meeting health care needs, methodology, feasibility for other medically underserved areas, costs of training and service, professional tasks, professional and social satisfaction, curriculum content, process and outcome of patient services, and types of health personnel most appropriate to given health service tasks. It describes a health care delivery system combining traditional health care with more decentralized, family-centered, community-based health care centers. Appendixes, forming more than one-half the report, include an FNS Midwifery and Family Nursing Catalogue, as well as information on organization, management, the team concept, service versus credential-based reimbursement, medical beliefs and practices in a rural Appalachian community, and the 1977 site team report of the American Nurses' Association. (RS)

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FINAL REPORT OF THE PRIMEX-FAMILY NURSE TRAINING PROGRAM IN RURAL AREAS

Grant Project No. HS.0085
March 1, 1972 - June 30, 1976
Frontier Nursing Service
Hyden, Kentucky 41749

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FRONTIER NURSING SERVICE, INC.

Final Report of The Primex-Family Nurse Training Program In Rural Areas

March 1, 1972 - June 30, 1976

Submitted by:

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FORWARD

This final report of the Frontier Nursing Service, Inc. is from one of seven Family Nurse Practitioner (PRIMEX) projects funded by the National Center for Health Services Research in 1971-72 in support of curriculum development and evaluation of the process and outcomes of such a program. While the goals and objectives of each project were the same, each approached these somewhat differently. Because this was a pioneering effort, an appropriate emphasis was placed on curriculum development and evaluation. Student selection and performance were process descriptors. Deployment thus far has been the major outcome variable.

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Very special recognition should go to Dr. Helen E. Browne who was the Director of the FNS when this grant was initiated. Without her vision and perseverence this project could not have been carried out.

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FRONTIER NURSING SERVICE

Final Report of The
Primex-Family Nurse Training Program
In Rural Areas
Grant Project No. HS.0085
March 1, 1972 - June 30, 1976

This is the final report of the Primex-Family Nurse Training Program in Rural Areas, as developed and implemented by the Frontier Nursing Service, Inc. (FNS). It incorporates goals, objectives, accomplishments, and recommendations.

I. DESCRIPTION OF THE REPORT:

Much of the change in the status of primary care nursing in this country and at the FNS is philosophical. Because no experimental design was developed, this report is largely descriptive. Statistical measures will be used where available and practical, but they alone cannot provide a complete picture of all that has transpired. Theoretical concepts and assumptions will be introduced within the context of the report to delineate developments that have been defined.

It was a series of fortuitous events that led the FNS to develop the Family Nurse Program but for the FNS to claim formation of new concepts would be pretentious. Those familiar with old literary works and history would soon recognize that none of the concepts are new, they are merely rearrangements of old ideas and practices developed by our forebears when similar problems were encountered. We have merely used new terms to identify old practices in health and medical services. These are reflected within the report.

New technologies have been added, but human traits (physiological, biological, sociological and psychological) remain the same, as does the order of the Universe. It is only the understanding of this order and our changing attitudes which have enabled us to formulate new solutions to the disorders we encounter and create.

II. ORIGINAL STATEMENT OF GOALS AND OBJECTIVES:

The purpose of the Frontier Nursing Service (FNS) Primex Project, as originally stated, was to request funds for a four year project designed to evaluate a training and service program for Family Nursing in an isolated rural area. The FNS (established in 1925) had created a nursing model for the provision of primary care in rural areas over a forty-six year period, and more recently (in 1969) developed a one year Family Nursing Training Program to assist in staffing such service units. This training (program) was an extension of the Nurse-Midwifery Training Program it had offered over a thirty year period (beginning in 1939).

The broad aims of the Primex Project were:

1) To evaluate the primary care training provided and the service model as it provided access to care and met health care needs.
2) To demonstrate a) methodology for such program development and, b) to assess the feasibility of developing similar training and service models in other parts of the country, where manpower shortages are prevalent.

3) To investigate costs of training and service; process and outcome of patient services; professional tasks; social and professional satisfaction; curriculum content; and the types of nurses and other health personnel most appropriate to given health service tasks.

The original goal was for each Primex Project to participate in the evaluation established through the National Center for Health Services Research (NCHSR). The aims of the FNS were in keeping with goals established by NCHSR. The FNS was able to accomplish a part of each of the aims.

III. ACCOMPLISHMENTS:

A. Introduction:

The introduction provides the background necessary to understand the accomplishments. Accomplishments of the Primex Projects in toto have far exceeded the original goals. The impact they have had on legislation and practice is astounding when contrasted with professional and legal opposition encountered when the FNS first began developing the primary care nurse training program. Recognizable signs of the nation's readiness to accept the concept of the primary care nurse were, however, evident in several areas when the program was initiated. This was reflected in the FNS study conducted by Booz-Allen Hamilton (1969) in preparation for developing the program, which was supported through the Appalachian Regional Commission. It was also reflected in national program development, i.e. in nurse-midwifery developments, and the pediatric nurse practitioner program developed by Ford and Silver, which was receiving wide publicity. These were all part of a much broader movement which included Medex and the Physician Assistant programs. This report addresses itself to primary care nursing only.

The interest and support primary care nursing is currently receiving both in the U.S. and abroad are well beyond early anticipation. Neither the notions, nor the concepts and practices of primary care could have taken their present form without the freedom to experiment that was built into the early Primex program development supported through the National Center for Health Service Research.

Without the exchange of ideas and the testing of new program models developed it would have been impossible to achieve what was originally planned. Of primary importance were the opportunities afforded to the six Primex Projects:

1) To share visions, goals, problems and accomplishments in developing primary care training and service models. All were experiencing similar frustrations and successes.
2) To investigate common approaches to primary health care delivery services, manpower utilization and health care training. These were previously considered unorthodox.

As a result the most amazing changes in attitudes and practices in health care are occurring not only in rural health agencies, but in all phases of health care, and health policies, including the preparation of health manpower. These changes were spearheaded by the new focus on primary health care services--an area of health care that had been long neglected.

The FNS received enthusiastic support from various and sundry areas in the early development of its Family Nurse Training Program. At the same time it experienced extreme difficulty in obtaining formal recognition from organized nursing and medicine, and acquiring federal funding for the operation of its program. Both were considered essential for its survival, and the development of primary care nursing.

The Nurse-Midwifery Program developed by the Frontier Nursing Service had operated successfully for thirty years, but its graduates were recognized only in a few states and abroad. Third party payors were not willing to reimburse an agency for the services the nurse-midwife provided. Acceptance of the nurse-midwife as an employee was rare. This was most unsatisfactory. It was a waste of good professional health care skills; it created problems in areas where health care was inadequate; and it was very demoralizing for the profession. The broadening of this program to include Family Nursing, served to create another badly needed group of health care providers that organized health and medical professions were not willing to accept.

For this reason, the program support made available through NCHSR, for experimentation, came at a very strategic time.

It provided the professional support which gave legitimacy to primary care nursing, and economic support which permitted the needed experimentation for sound program development. Program development in diverse settings, geographic and demographic areas, created a greater impact than could have been accomplished by any one program alone. What gave it strength were the similar goals and central evaluation system.

The diffusion created through this system made it difficult to attribute success to any one group or specific factor. Through these efforts new potentials in health care were brought to the awareness of interested citizens, professionals and legislators. The resulting developments made it difficult to pinpoint those factors that were most pertinent to the successes of the program. When viewed in retrospect, it becomes an amalgam of actions appropriate to the time, the professions, and the needs of the nation.

In 1971, when Gertrude Isaacs presented a paper at the Conference on Rural and Appalachian Health on "The Family Nurse and Primary Health Care in Rural Areas", the moderator questioned whether the country was ready for this notion. In 1973 when it was published in Rural and Appalachian Health, Nolan and Schwartz, (1973), the proposal for establishing separate regulations for primary health care was questioned, and the proposed role for the primary care nurse was ignored. In 1975, when reviewed by Kane (1975), it was one of the two papers singled out of twenty-five as having anything significant to contribute to health care development.

This movement has continued to proceed in an orderly fashion, without any major interruptions. Obstacles have been gradually overcome as successes have been demonstrated. Below are some of the changes that demonstrate increasing professional organization endorsement, as well as state and federal legislative and financial support of the primary care nurse. All have come to fruition in the past year:

1) Kentucky has developed rules and regulations for licensure of primary care centers that include provisions for reimbursement of preventive and health maintenance care, and primary care nursing;
2) The Kentucky Primary Care Association (interdisciplinary) has been incorporated for the promotion of primary care development;
3) The Federal Government has introduced legislation to support primary care nursing services in Medicare;
4) The ANA is accrediting non-university primary care nurse training programs, along with university programs, and certifying the graduates through national examinations, utilizing the same criteria; and
5) The Division of Nursing provides funding for the training of the primary care nurse in certificate and university programs.

Areas that are still problematic are:

1) The implementation of a satisfactory reimbursement program for primary care services which incorporates preventive, maintenance and curative care. This should

cover the whole family, in a single program; and provide an acceptable audit system to assure quality of care, regardless of skill level of provider.

2) State and national legal recognition of the primary care nurse as an acceptable health care practitioner; and

3) Academic credit for certificate programs or other appropriate mechanisms of professional recognition of the formal training provided.

Each of the above requires State and/or National action which an individual program cannot accomplish for itself.

Increasing acceptance by other professions will be more readily achieved when the above is accomplished. For example, medical acceptance of the primary care nurse, as a collegial member of the health team, is still very sporadic in the Commonwealth of Kentucky. Official support of the primary care nurse by the Kentucky Medical Association is still pending. Such conflicts between medicine and nursing must be resolved to assure greater complementation rather than competition within the health field. When this is accomplished joint practice involving other disciplines should be easier to achieve. Health care can then become goal oriented rather than profession oriented.

B. Outline of Accomplishments:

The most important accomplishments of the FNS Primex Project can be categorized as follows:

1. The continuing development and evaluation of a satisfactory training program for primary care nurses in a rural primary care service agency.

a. The evolvement and implementation of a coordinated service and training philosophy that meets service, training, and provider needs;

b. The continuing development and implementation of service-learning oriented curriculum in primary care nursing;

c. The recruitment and development of faculty for functioning in a service agency with an appropriate organizational structure;

d. The recruitment, admission criteria, and evaluation of students.

2. Development of a methodology for assessing health services and findings, using the encounter form as a means for collecting data and findings in relation to:

    a. Productivity and accessibility;

    b. Quality of services;

    c. Quality of care and outcome studies;

    d. Health care costs in a decentralized, family centered, community based service agency versus traditional service agencies.

3. Training Costs

4. Demonstration and documentation of the role that an organized primary care education and service center can play in:

    a. Formulating more feasible and practical approaches to health care;

    b. Health manpower recruitment and development;

    c. Renewal of interest in rural primary care services;

    d. Linkages with specialty care and educational institutions.

C. Report of Accomplishments:

1. The continuing development and evaluation of a satisfactory training program for primary care nurses in a rural primary care service agency.

The history of service and training development at the FNS, its basic purpose, stated objectives, and the philosophy upon which the program is based are described briefly in the Catalogue of the Frontier School of Midwifery and Family Nursing. (Appendix A, School Catalogue, p. 1-4) It will not be repeated in this report.

It portrays a consistant effort directed toward orderly development of a service-learning oriented education program and carefully planned utilization of limited resources in response to the health needs of the citizens within rural areas.

For the purposes of this report the important elements of the objectives as originally formulated are: (School Catalogue Appendix A, p. 2)

a) The use of nurse-midwives to bring health services into the community and home environs in a medically underserved area (this was later broadened to include family nurses and pediatric nurse practitioners and other related practitioners).

b) The emphasis placed upon health education of the people, particularly the mothers, as an integral part of the program to enable the family to cope more effectively with every day health problems, to develop a life style that is conducive to good health and to maintain a safe clean environment;

c) The need for involving its citizens in ameliorating those conditions which are inimical to health;

d) The need for developing linkages with medical and health related agencies to make the most modern technology available to rural areas, no matter how isolated; and

e) The need for involving leading citizens in health planning to meet local needs;

f) Health manpower training; and

g) The need for coordinating efforts and resources at all levels, local, state and federal.

These elements are still as vital as they were at the time they were written in 1925.

a. Evolvement and implementation of a coordinated service and training philosophy.

To assure sound coordination between service and education during the process of developing this project:

1) Education and service administration worked in close coordination. All planned change was carefully reviewed for its potential impact on both the service and training programs, 1) prior to its initiation, 2) upon implementation, and 3) following implementation. If adverse reactions were noted, careful investigation ensued. All staff members (education and service),

as well as students were encouraged to participate in the evaluation. In the beginning, the process remained very informal. As the program participants increased, more structure was introduced.

2) The Board of Governors, administration and staff met annually for review of immediate and long range goals. They met with students in 1975 for a two day interim review of its goals and objectives and their reinforcement, following the development and implementation of the Family Nurse Program. Selected local citizens were also represented at this meeting.

3) The School developed an organizational structure which provided a mechanism for, and promoted full participation by staff, faculty and students in late 1975. It should be noted that all faculty and students have service responsibilities and service staff have educational responsibilities. The organizational structure for the education program provides for joint meetings which include service and teaching staff and students. (Organizational Chart, Appendix B)

4) The Community Advisory Committee now meets bi-weekly to advise the administration.

While full participation in the organizational structure was difficult to attain, both staff and students now find it most helpful and productive. Student participation has become increasingly constructive as they have become privy to:

a) problems encountered (internal and external)

b) discussions regarding their resolutions

c) actions proposed and implemented

d) evaluation of changes initiated

e) retrenchment and/or reinforcement of changes based on the evaluation.

The rapport and communications between staff and students has been markedly strengthened in the process. As a consequence each has grown in self confidence. It is believed that the above are closely interrelated, i.e. as faculty become more confident, their self image improves along with their competencies. At the same time students become less of a threat, their criticisms less destructive and their participation more constructive. It is the above interaction that creates improved rapport and communications. This interaction requires constant input on the part of administration, who must remain alert to the importance of little irritations and the need for openness in the discussion of both short comings and strengths. Both students and staff require continuing supportive back-up. Complaints must be curbed, positive action encouraged, and a sense of humor maintained.

Under these circumstances staff together with students have been able to jointly participate in continuing evolvement of educational and service philosophies and practices. Below are three pertinent areas that have been mutually developed.
1) The management approach. (Appendix C) This includes

the basic principles followed in the management of health care, delineating the relationships between student, staff, teacher and consultant in both teaching and service programs, and their relationship with the patient and the family.

2) The team concept implemented in 1976 as a result of a student project. (Appendix D) This is still in the experimental stage and needs careful evaluation. There is some feeling that this concept as implemented has reinforced the superiority of the physician and the deference of the nurse in a detrimental manner. Continued collaborative evaluation of the process will hopefully strengthen the collegial relationships it was intended to promote without forgetting the individual

3) Clearer delineation of responsibility in the health field.
   a) The responsibilities of the individual and his family for their own health care and health status based on Bellac and Breslow's (1972) longitudinal study of the impact of health practices; Lalonde's (1974) report on New Perspectives of the Health of Canadians, which focuses on the impact of the life style of individuals; and Levin (1975) who promotes the concept of self care, which provide guidelines for individual and family participation in their own care.
   b) The responsibilities of the community for health services as amplified by Rosen (1976), and health related responsibilities of the community according to Lalonde (1974), which hold the community accountable for very concrete activities in the health field. These require the joint action of a wide range of

experts together with community participation and support.

c) The responsibilities of organized health care agencies which incorporate the direct health care services provided and the collaboration with the individual, his family and the community, in planning and implementing health services, including health manpower preparation.

These may be divided into three major areas:

Primary Health Care
Primary Medical Care
Specialty Care or Tertiary Care

While there is overlap in these functions, each has a meaningful, pertinent and complimentary role to play in the health field, which must be delineated if each is to assume an appropriate share of accountability and responsibility for self and for others. It is particularly useful to the developing professional in helping him gain an appropriate perspective of his own role in the health field in relation to others.

The overall responsibilities for health care may be delineated into the three areas in the Figure 1.

FIGURE 1

A. Self & Family Care Health Practices and Life Style As Related To:

1) Diet
2) Relaxation and Sleep
3) Physical, Social and Mental Activity
4) Environmental Safety
5) Alcohol, Smoking, Drug Use and Abuse

B. Community Services

1) Safe Food & Water Supply
2) Clean safe envirnment and housing
3) Safe Transportation System
4) Adequate Communication System

C. Organized Health Care

1) Health Maintenance Services, Education and Counseling
2) Preventive measure, e.g. control of infectious disease
3) Crisis Intervention

A. Continued

6) Appropriate interpersonal and social behavior
7) Management of Stress and Crises

B. Continued

5) Job Opportunities
6) Recreational and Social/Cultural Opportunities
7) Organized Health, Education, Social and Governmental Services

C. Continued

4) Early identification, management and care of the sick and disabled
5) Teaching self/family care in health, illness and disability
6) Medical diagnosis and treatment of disease and trauma
7) Rehabilitation of the temporary and permanently disabled

The above will be explored in more detail in future writings. These three categories are currently being incorporated within the educational program to assist the family nurse students to understand and clarify their own responsibilities in relation to the consumer, the community and other health care providers. These clarifications are deemed essential for purposes of role definition and to assist students and practitioners to delimit, in a realistic manner, the perimeters of their self-expectations; to establish reasonable expectations of others--consumers, providers, administration, legislation; and to provide a baseline for arbitration where lines of responsibility are ill-defined.

b. Development and implementation of a service-learning oriented curriculum.

The Frontier Nursing Service was selected for the development of the educational program because of its long history of coordinating service responsibility with education. This philosophy is amplified in the Atlanta Service-Learning Conference Report (1970).

The advantages of a service-learning oriented curriculum are:

1) The incentives for learning created through service responsibility.
2) The coordination of practice and theory within the curriculum to produce a more-reality oriented (practice versus theory) approach to service, and to strengthen incentives for exploring more effective and efficient approaches to health care.
3) The creation of a stronger professional identity during the training process through the interface of education and service responsibility. This is considered essential to the development of self confidence and commitment. Both are essential for a life of service that enables one to share and give of self in a professionally satisfying manner, without guilt and/or self-pity. This will be discussed in later writings.

Service-learning curriculum refers to the plans incorporated within the program that provide opportunities for the student to assume direct responsibility for service up to the level of his competency. It is assumed that because the nurse comes to the program as a professional health care provider with basic knowledge and skills, one can safely expect that:

1) She can recognize certain health and medical problems.
2) She will utilize professional caution and not institute plans of care or treatment unless she is confident of the correctness of the procedure.
3) She will seek consultation when in doubt.

4) If consultation is not immediately available she will use what emergency measures are indicated, seek the needed help and assurance of the appropriateness of the action taken should she encounter a similar situation later.

To help students follow this scheme, faculty have developed "The Management Approach to Care" which is followed throughout the program. (Appendix C) Through this process students are helped to assume increasing responsibility as they gain new knowledge and competencies in health care.

During the first trimester* students spend two full days a week in the clinical area and take call with a second trimester student. In the second trimester students spend 3 full days a week in the clinic and take first call with a family nurse and a physician immediately available via telephone and within five to ten minutes travel distance. This provides students with the opportunity of applying classroom theory in real life situations. From the beginning they are expected to take on responsibilities for making clinical decisions on the basis of their competencies.

The development of clinical judgment is thus nurtured and encouraged. Students experience a very keen satisfaction with the development of growing expertise--the evolvement of their professional identity. This is most profound when they see the care they provide being effective. If it fails there is a real incentive to learn why. The availability of supportive clinical instruction is vital to this learning process, as are the direct instructions with the patient, his family, and other members of the community, health agencies and organizations.

*A trimester is equivalent to a semester in most Universities.

Curriculum Content:

Prior to developing basic curriculum content Dr. Beasley, (a physician) and Dr. Isaacs, (a nurse) spent several months talking to and observing the district nurse-midwives at the FNS who were functioning as family nurses. Both Dr's. Beasley and Isaacs had had several years of prior staff experience with the Frontier Nursing Service, together with a broad range of experience and education in the health field in both rural and urban areas. In addition a visit was made to a primary care nursing training program (Outpost Nursing) conducted at Dalhousie University, Halifax, Nova Scotia, Canada, by Ruth May, a former nurse-midwifery graduate of the FNS. This was the first program of its kind to be developed. The objectives of the Family Nurse Training Program at the FNS were developed on the basis of the above observations. Only minor editorial changes have been made in these objectives since they were first developed. (School Catalogue Appendix A, p. 7-8)

In addition, a study was conducted by Benjamin (1969), a medical student from the University of Kentucky, which identified those conditions most commonly managed by the nurse-midwife and the registered nurse in the clinic setting at the FNS. Because of the shortage of medical manpower the nurse using medical protocol had been managing 90% of the patient encounters. At the time this program was implemented, the FNS was fortunate to have one resident physician. In 1969 when Dr. Isaacs joined the staff, the FNS had one volunteer physician on staff, Dr. Anne Wasson, who later joined the staff to become the prime medical instructor in family nursing. Recruitment of health manpower personnel will be discussed in greater detail later.

The early curriculum content was based on the study done by Benjamin (1969). Curriculum was planned to cover the basic physiological systems, the normal biological and physical functions, the identification of the common abnormalities, their management, their social and psychological impact, and the point at which to seek medical or other consultation. This included history taking and physical examination, appropriate lab tests and other diagnostic procedures and treatment measures.

The Medical Directives (1972, 1975) were revised to cover the conditions the family nurses and nurse-midwives were expected to manage. This protocol provides the guidelines, the privileges and limitations in the performance of medical functions. These were mutually developed by the Frontier Nursing Service medical and nursing staff with consultation from its Medical Advisory Committee and other medical specialists from the University of Kentucky, who participated in the teaching program as visiting lecturers. The FNS pharmacist and the University of Kentucky College of Pharmacy also participated. The system for controlling the distribution and prescription of drugs, to be used by the primary care nurse, were mutually developed. (Appendix E)

The curriculum content was aligned in the order of the problems most commonly encountered. Because respiratory problems were the most commonly encountered problems this was the first system taught. This provided the advantage of learning first about that system and those conditions most commonly encountered in health care management. Through this approach students could most rapidly gain self confidence in diagnosis and management. This approach was also most expedient. A 1974 study of diagnostic categories most commonly encountered indicated a similar distribution. The frequency of diagnostic categories encountered in both 1969 and 1974 are noted in Table I. The ranks however have changed.

This general approach to curriculum development is still followed, though content is presented in much greater detail, and students now receive a two week intensive course in which they are taught to do a complete physical on one another, using Bates (1974) textbook and films, before they enter the clinical practicum.

Much of the content is presented through the use of case material. Because faculty is present with the student in the clinical area, they can draw upon case material which is not only relevant but it provides a real life situation that adds substance to the theory. It highlights the short comings as well as the advantages of familiarity with the written word. Most important, it teaches the student to develop her own observational skills, to develop a systematic approach to health assessment and problem management, and not to rely too heavily upon theory--an important factor in developing professional identity. Very few cases observed in the clinical setting are textbook perfect. One must learn to consider all the ramifications that may impinge upon a given condition.

In the beginning the program offered only three four month trimesters. After completion of the first trimester "Diagnosis and Management of Common Health Problems", students were given

TABLE I

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Comparative Study of Leading Diagnostic Categories 1969 - 1974*

Order of Diagnostic Categories	Percentage of Visits		Rank According To Frequency	
	1969	1974	1969	1974
Preventive Care	23.9	11.4	1	2
URI's Including Strep Throat	14.2	12.3	2	1
Gastrointestinal Conditions	9.4	3.5	3	10
Injuries	8.4	5.2	4	6
Hypertension	7.6	7.5	5	4
Genito Urinary Conditions	7.5	4.2	6	8
Antepartum Visits	5.3	5.0	7	7
Other Respiratory Conditions	5.2	10.5	8	3
Cardiovascular Conditions	4.2	7.2	9	5
Intestinal Parasites	3.3	1.8	10	13
Diabetes	2.6	3.9	11	9
Vaginal Conditions & Menstrual Disorders	2.4	2.3	12	12
Anemias	2.2	1.5	13	14
Arthritis	1.4	2.9	14	11

*Total Number of Visits:

FY 1969 - 61,324
CY 1974 - 54,504

a Family Nurse Associate Certificate or a Certificate in Family Nursing if they had previously completed a nurse-midwifery program. After completion of the second trimester, "Prenatal, Postpartum, Infant Care, and Family Planning" students received a Family Nurse Certificate; and after completion of the third trimester "Intrapartal Care and Management of the High Risk Mother and Infant" students received a Family Nurse-Midwife Certificate. The total program prepared a well-rounded primary care nurse for rural areas.

In 1974, students were required to complete a four month internship in family nursing and/or nurse-midwifery, as part of the program. The purpose was to increase their clinical expertise, and to lessen the turnover in the clinical area. This was beginning to create a problem in the community. In an outpatient department continuity of care may be seriously disrupted by rapid turnover of students. This rapid turnover limited student opportunity for becoming familiar with the impact of illness and the response of the patient to care. For these reasons it is advantageous to both students and patients to keep turnover to a minimum. The internship was considered most beneficial.

In 1975, the first trimester was divided into two trimesters, lengthening the program by four months. The content incorporated in the first trimester had been increasing gradually, and after the school had sufficient faculty the decision was made to divide the content into two areas. The content of the first trimester was limited to health assessment and health management. This permitted more time to learn history taking and do physical examinations; to study families and assess their ability to cope with health and health related problems; and to learn more about preventive and health maintenance measures--health education and counseling. A graduate course in physiology was also added to provide a more thorough understanding of the normal upon which to base preventive care and understand pathophysiology. This division of content also permitted more time to study the various laboratory tests, and their significance. The physiology course is taught by the University of Kentucky Department of Physiology. Audiovisual tapes of University lectures are used.

The next trimester's content could then be devoted more fully to the diagnosis and management of common health problems, with more detailed content in pathophysiology and its response to treatment. Stress and crisis intervention could also be strenthened with greater opportunity for concentrating on its identification and management as it affects physical, mental, and social well-being, and as a treatment mechanism in the reduction of mental illness. A health educator and a social worker were added to the staff to help broaden the educational and counseling content in all areas. The lengthening of this the program doubled the amount of clinical experience that is so important in the development of clinical expertise and professional identity.

This breakdown of the first trimester had another advantage. Health assessment and health management had been considered an essential prerequisite for nurse-midwifery. This division of content permitted students to move from the first trimester directly into nurse-midwifery without taking the semester on pathology, which was considered valuable but not essential for nurse-midwifery. There are always a few students in the class who decide that family nursing is not their cup of tea, and that nurse-midwifery is the field of health care to which they wish to devote themselves. Others decide that the family nurse component is all they really want.

This makes both the family nurse and the nurse-midwifery program one year in length with the option of completing both in 16 months. (School Catalogue Appendix A, p.8-9 for the outline of the program as currently offered.)

It should be noted that all instructors tend to feel that they have inadequate time to teach their area of content, so that faculty is continually faced with the problem of identifying that content which is most pertinent to family health and nurse-midwifery practice. This is difficult. To a certain extent the content identified depends largely on the manner in which faculty view health care, whether they see the family nurse focusing primarily on prevention and maintenance care or whether they see her more in the curative role; whether they see illness primarily from a physical point of view or whether they are attune to the social and mental aspects of health.

Each of the faculty brings a different focus to the program. The students then incorporate that content which they find most meaningful in their management of patient care. The inability to cover all things in the program must be accepted. The need to continue to circumscribe and delimit those functions appropriate to family nursing and nurse-midwifery practice are essential. This means that faculty must learn to be selective, and help students to develop an inquisitive nature, with tools for continuing their own learning after they complete the program. At the same time they must help students to recognize the appropriate opportunities and limitations of their role, as well as appropriate mechanisms for redefinition of role, depending on settings and circumstances.

Students are exposed to the full gamut of family care including all age groups, the needs and responsibilities of the individual and the family for their own health; and the assessment and management of health, illnesses (chronic and acute), disabilities, and trauma by the health care provider. They have opportunities for assessment and management of health and illness in the home, the clinic and the hospital. They are taught to differentiate between those conditions the family may be expected to manage, those they can manage, and those that need to be referred to others, and how to refer and consult. The aim is to help them become comfortable in assessing their abilities and limitations, in order to assist the individual and his family to do likewise.

Special attention is paid to the need for continuing education, since only a small portion of health knowledge is taught in the program. Technology is continuously changing and health care management a continuous learning process. Continuing education is built into the service and training program through the availability of programmed instruction, extensive audiovisual material and extra planned seminars and conferences. It is presented as a continuing need, an opportunity and a challenge throughout the program.

In the course of developing curriculum content, faculty have continually redefined and refined that content which is considered essential. Behavioral objectives have been established for the various courses of each trimester, which are considered basic and may not be changed without faculty and student approval. Individual faculty establish content, bibliography, method of presentation and evaluation around these objectives. These are being developed in the form of modules, which provide students with well defined objectives and guidelines for that content expected to be mastered. It promotes independent study and mastery of each of the different areas, and faculty are provided with a basis for evaluating the student. Appendix F contains the behavioral objectives for the total program and Appendix G, a sample module.

Faculty have developed different types of modules, and the manner in which they are utilized varies. Some faculty use lecture and seminars as a means of complementing modular content. Others use modules primarily as guidelines.

Modular content in nurse-midwifery is at a more advanced stage of development than in family nursing. Content to be mastered has been more clearly defined and the role of the nurse-midwife is better established. The content to be covered in nurse-midwifery is not as broad and has a long history and tradition. While the role of the family nurse has a similar philosophical base, it is much more difficult to define and delimit due to the wide ranges of diseases, disabilities, problems, and age groups to be managed in family health.

It should be noted that both faculty and students feel relatively comfortable with the progress made in establishing an appropriate role, and the content that is required at the present stage of role and curriculum development in Family Nursing. Time spent in the clinical area and in the classroom has remained equally divided throughout the development of the program. This ratio is strongly supported by both students and faculty.

In 1976, requirement for the internship was changed to a one year commitment on FNS staff, upon completion of the program. Students sponsored by other agencies are exempted from this commitment. The educational content offered during the internship will be built into the continuing education program for beginning staff. This one year commitment will help graduates meet the clinical requirement for their national examinations. At the same time it will further reduce the rapid turnover that is so disruptive to service and the community. This requirement is supported by both students and staff.

The pre-admission employment requirement no longer necessary to maintain adequate staff was discontinued. It too, was very disruptive of service. It was a built-in rapid turnover staffing mechanism that had outlived its usefulness in relation to service.

Students will have less familiarity with the philosophy of the service, its management policies and its practices, and with the community, its people and resources. It is expected that an added strain and burden will be placed on the faculty and the students. It is, however, a trade-off considered appropriate to the present stage of development. A one month orientation program has been developed to lessen this strain.

The FNS is currently in the process of developing a contract with the University of Kentucky College of Nursing whereby University credit for selected approved courses offered by the FNS facility with joint appointments, may be given. The effect this will have upon the program is as yet unknown. A Division Of Nursing HEW Grant was awarded to the FNS in 1974 for this purpose. The aims of these two grants were closely coordinated.

This report does not reflect the turmoil through which administration, faculty and students went in their effort to develop a meaningful curriculum in rural primary health care. Words cannot depict either the icy silence nor the direct hostility frequently encountered during the development of this program, when first introduced. The lack of access to a modern Medical Library, and limited funds for buying the basic essentials were minor obstacles compared with the lack of early professional acceptance. These obstacles have been largely overcome.

Curriculum Evaluation:

Training program evaluation encompasses two aspects, curriculum evaluation and student evaluation.

Since no theoretical framework was available for curriculum evaluation and the role of the family nurse was too new to allow evaluation to be molded by a pre-determined design. It evolved out of practical experience.

Curriculum evaluation played a very significant role in a) content development and realignment; and b) teaching methods. In the beginning, the process used remained relatively informal. Increasing structure was established through experimentation and faculty support. Methods that seemed unsuccessful were relinquished, sometimes to be tried a second or third time. Successes were embellished as this seemed appropriate. Since there was no prior family nurse curriculum, the process was frequently one of trial and error. The atmosphere was relatively open for experimentation, with options for faculty veto.

From the beginning students participated in the evaluation process, and gradually assumed increasing responsibility for decision-making. This was a growing process directly related to development of faculty self confidence, as well as greater confidence in quality, acceptance and appropriateness of the program developed. This can only be achieved through experience and sound program administration.

At the end of each trimester students were asked to submit a written evaluation of content offered (classroom and clinical) and teaching methods Students met with faculty, service staff and administration for discussion of the evaluation and proposed changes. Following this, administration and faculty met to identify those changes that could be realistically incorporated within the next semester.

When faculty meetings and student council became more formalized in 1976, (Appendix B, Organizational Chart) channels for evaluation took on a more constructive pattern. The most notable change occurred in student participation. The student council provided an excellent avenue for presenting grievances, satisfactions and proposed changes. These were presented at the faculty meeting only after careful review and consideration by the student council. Presentations at faculty meetings were frequently preceeded by informal discussions with faculty. Faculty utilized a similar pattern of introducing proposed changes. These were usually presented and discussed at one of the subcommittees, or if presented at the Faculty Meeting they were frequently referred to the appropriate subcommittee for refinement. Ad hoc committees were established as indicated. Faculty meetings provided each an opportunity to bring up problems and to discuss pros and cons to be determined by vote. This system developed a strong sense of belonging and responsibility, that could not be achieved by the less formal methods.

Resistance to the more structured approach was difficult to overcome until the Primex grant was nearing its completion. At that time an appeal was made to FNS administration to offer their support. A proposed organizational chart was presented for discussion and accepted by vote for experimentation. A year later it was announced a success and acclaimed by both faculty and students. Student participation in the various committees is being expended gradually upon their request and faculty acceptance. So far none of their requests have been turned down. This has been the most satisfying evidence of professional growth. Only minor changes have been made.

The evaluations have been instrumental in establishing a collegial tone in the teaching methods. They helped to promote a more collaborative relationship between faculty and students with increasing acceptance of student participation in teaching functions. This has significantly lowered the elitist barriers between faculty and students; as well as inspired a new respect for each other.

It has created a teaching-learning atmosphere without rival. The freedom to reveal strengths and shortcomings reduces tensions that slowly filters through to the patient and their families--an atmosphere that is essential for promoting increased responsibility for self care. It is a democratic process in action.

This teaching-learning atmosphere does not however circumvent the need for faculty to set a tone of high expectation, and to remain alert to the anxieties that students frequently experience when they find themselves unable to meet expectations set by either self or faculty.

Increased emphasis has been directed toward process, but not to the exclusion of theory. The aim is to help students combine the two.

1) Process involves observation, recognition, interpretation, definition, clinical judgment and management of patient

care--the art and skills learned by doing.

2) Theory involves the understanding, knowledge and concept formation acquired through listening, reading, discussion and meditation. This makes process meaningful.

Program objectives could not be broadened into behavioral objectives for the various components of each trimester, until faculty that had received preparation in curriculum development at the Master's level was acquired. These were further delineated when FNS faculty met with the University of Kentucky College of Nursing faculty through a joint grant from the Division of Nursing, for university affiliation. These behavioral objectives were accepted by the University of Kentucky College of Nursing faculty for their graduate curriculum in Family Nursing. (Appendix F) Faculty also worked together on the development of the modular curriculum with Vanderbilt College of Family Nursing faculty and the University of Mississippi Nurse-Midwifery faculty. Such collaborative endeavors provide excellent opportunities for joint curriculum development and evaluation. Medical faculty from the University of Kentucky Medical College have participated in the teaching activities and demonstrated interest in the program from the beginning.

These modules, as mentioned earlier, are designed to provide both students and faculty with guidelines of expected learnings and competencies. (Appendix G) They are designed to help students assume greater responsibility for their own learning and self evaluation. They also help faculty keep their expectation at a realistic level. The modules are supplemented by lectures which help keep learning and teaching current and relevant, and seminars which permit the interchange between faculty and students that keep the focus on current happenings in the field of health care. These discussions are essential for student comprehension of clinical experiences, community problems and administrative details that are basic to development of clinical practice, and to the delineation of their role. All are essential for student and curriculum evaluation, which remains a continuing process.

c. Recruitment and development of faculty for functioning in a service agency with an appropriate organizational structure. The recruitment and development of faculty for functioning in a service-based agency has been and remains a continuing process and responsibility of the teaching, service, and administrative staff, since this is a collaborative program. This sometimes creates problems.

In May 1969, the FNS conducted a Conference (1969) to explore Family Nurse Program development by inviting former staff currently employed in educational institutions. An intensive study conducted by Booz-Allen Hamilton (1969), surveyed the need for family nursing in rural health. This study, together with their recommendations for the development of a Master's program, formed the base for the discussion. The pros and cons of a Master's program were discussed together with aims, goals, and type of faculty required. The general consensus was that both a Master's and a certificate program were needed. It was agreed that the program required a Medical and Nursing Co-Director and that both medical and nursing faculty were needed. The pattern proposed was very similar to that followed in the nurse-midwifery program.

The desired qualifications of the nursing co-director were discussed at length. Because the role of the family nurse was still to be developed, it was proposed that the nurse co-director should preferably be a nurse with midwifery and an M.P.H. While a doctorate was mentioned, the group felt that this was unrealistic, but in the end they recruited the one conference participant, Gertrude Isaacs, D.N.Sc., M.P.H., C.N.M. that had all three degrees as the nursing co-director. She joined the staff in the summer of 1969. W.R.B. Beasley, M.D. had previously agreed to join the staff as the medical co-director in the fall of 1969. A grant was submitted to the Appalachian Regional Commission for the development of the Family Nursing Training Program. This grant was awarded in January 1970.

At the time that the program was initiated, in June 1970, the FNS had three nurse-midwifery faculty members in the Nurse-Midwifery Training Program. In addition, two district nurse-midwives, and one district nurse were asked to participate in the teaching of family nursing. Only one of the nurse-midwifery faculty had a Master's degree, an M.P.H. Two general practice physicians were recruited as part-time instructors in family nursing. One had prior experience in teaching primary health care in Gonda, Ethiopia. Dr. Beasley provided instruction in obstetrics and family planning in conjunction with the nurse-midwifery faculty. Dr. Isaacs participated in both family nursing and nurse-midwifery instruction.

The developmental grant was designed to provide for joint program development with Vanderbilt University. An educational conference was developed to explore curriculum development for family nursing as part of this grant. Seven nursing educator's were invited, including Vanderbilt University faculty. Most of the six weeks were spent in debating whether content should be taught at the certificate, baccalaureate, or Master's level. The FNS remained adamant throughout, that both certificate and Master's level preparation was essential to produce sufficient rural practitioners and well qualified faculty and leadership personnel in family nursing. The position was based on FNS's past experience with the nurse-midwifery program, both service and education. General definitions of role and functions of the family nurse were delineated at this conference.

Recruitment continued to remain a major problem, largely because of low salary, long working hours, the isolation of the area, and limited understanding of primary health care as a legitimate nursing role, and the FNS stance on certificate education. Housing was limited, so were the facilities. Secretarial and administrative assistance was almost non existent. To develop a new program in an isolated, and an economically and educationally deprived area under these circumstances required patience and perseverance. The FNS frequently found that the goals for its educational program were too forward looking for the service and the community to absorb comfortably. Nor was the FNS always able to recruit and house the desired personnel.

At the same time there was a high degree of internal and external pressure to push ahead, to demonstrate and document research findings which would permit legal recognition and reimbursement of primary health and nursing care . This in turn was necessary to enable the service and the education program to remain viable, and establish reasonable standards for education and service. It was a vicious circle that was difficult to contain within reasonable limits.

The intensity of the pressures was difficult to predict or contain primarily because they were both externally and internally induced, and intensified by the pressures each was experiencing. All seemed to be straining equally for high standards of care and teaching, because the thought of failure was incomprehensible. These pressures were heightened by the lack of established lines of expectations or limitations against which to measure the progress made.

Until these were defined the organization experienced a high degree of frustration. This was enhanced by its deep devotion to the community, and the dual nature of its responsibility for both service and education. It was, however, the very nature of this dual responsibility that created the needed esprit de corps that made it possible for the agency to endure and tolerate the resulting ambiguities and to carry on often in dire adversity.

To appreciate the nature of this responsibility to the community it is necessary to understand the long history of service established, the extreme poverty and isolation of the area, and the devotion and trust that was established between the people and the service agency. The education program was established to enable the service agency to carry on. There was no outside education program willing or prepared to train primary care nurses for rural areas and the FNS was dependant upon these nurses. State and federal agencies were continually up-grading standards and regulations with more rigid requirements for medical supervision. The community became more conscious of the prestige of medical care as outside contact increased. At the same time funding was limited; costs were rising; and legal recognition was postponed. Under these circumstances, it was well nigh impossible to recruit traditional health manpower to maintain the quality of care that had been established by the nurses. There seemed to be no option but to move forward.

At the same time that the community was requesting more medical care and better hospital facilities, without a full comprehension of their costs, outside philanthropies and donors who had maintained the nursing service were not willing to provide the monies needed for changing the FNS into a traditional medical service after its illustrious history. Nor did the community want to switch to a strictly medical service. They wanted the best of both. For these reasons the FNS had to recruit nurses and physicians who were interested in maintaining a service and an educational program that promoted joint primary care practice. It also had to seek funding to maintain such a program. Neither the State nor the Federal government were persuaded of the efficacy of the program, and its applicability to other areas. At the same time, the Frontier Nursing Service, after many years of service, was hesitant to expand its program beyond its capabilities. It is most difficult to retrench a program after it has been overextended, without total destruction; and the community did not have the financial means to maintain the program. Few local people with high school educations entered professional training and of those who did, few returned to the County because of changed expectations and the low salaries offered.

All of the above factors had to be carefully considered before recruiting new staff. In addition, the community is very conservative. The people have been exploited in every conceivable manner by industry (coal and lumber), curiosity seekers (federal and academic), and do-gooders (academicians, philanthropists, and religious orders). Most were more intent upon meeting their own special interests rather than becoming a part of the community in its struggle to remain self sufficient and to become a thriving community. While the community recognizes its dependance upon others, it is hesitant to relinquish the independance that their life style offers them and that has been essential for survival. The accompanying pride has given them a dignity and a sense of privacy that many still cherish beyond any affluency that a different life style or community might offer them. For this reason they continue to shun interfering outsiders; and few outsiders ever become true and accepted members of the community with all its privileges and responsibilities.

Most of the staff that join the service come as transients, to learn what they can, to provide a little service, and then to move on. This makes stability a very difficult thing to accomplish. The FNS is, therefore, continually looking for those who can give stability to the program without making it an ego trip, and for someone who has a true appreciation of:

1) the values that are inherent in the mountain culture where life is a constant struggle with the environment;
2) the delicate balance that exists between man and nature under these circumstances;
3) the courage required to face the challenges of survival under these circumstances; and
4) who is not condescending in his/her manner.

It is a state of existence on which our forefathers thrived.

The introduction of a new program of this nature into such a culture calls for careful consideration and continuing evaluation of the impact it has on the community and its people. A study conducted in 1974 by Dr. Marian Pearsall, Ph.D., an anthropologist on the University of Kentucky staff presents an extensive portrayal of this area, its medical beliefs, past experience, and use of health services in a rural Appalachian community. (Appendix H) To maintain a satisfactory and viable staff under the above circumstances requires considerable effort. It is not unique to the Appalachian Region.

As the service and education became increasingly sophisticated in meeting standards established by outside agencies, recruitment becomes less complex. In the process it lost some of its essence. The FNS would, however, like to believe that the outside world has learned to accept some of the mountain values in the process, that it has become more tolerant of those areas in which we differ, and less insistent that we all subscribe to the same standards and beliefs.

It should be noted that the FNS has employed two local registered nurses in the past three years. Most of its L.P.N.'s and nursing aides are local people. Its pharmacist is also a native of the county. There is one physician from this area that returned to private practice in this county and two other registered nurses from this area are currently employed in the county. The local vocational school has recently initiated an aide training program which was formerly offered through the FNS.

Table II below shows the number and type of professional staff members that were employed by the FNS at the time the program was initiated and the staff that is currently employed. This increase in staff has vastly broadened the opportunities for interdisciplinary team work in both the service and teaching programs. It has also created many problems in the attempt to assure maximum utilization of each new member of the team to the maximum benefit of all.

The table shows major changes in the distribution of personnel employed. The most significant change in distribution is the increase among the physicians and the lab and x-ray technicians. Physicians increased from 2-8; and lab and x-ray technicians from 1 to a total of 7. Primary care nurses have increased by 6, from 18-24, but their overall distribution has decreased from 12% to 10.4% of total employees. All other health care care and business and management staff have increased in both

TABLE II

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Number and Percentage of Employees in
Service, Education and Maintenance According to Type and Placement
February 1969 and February 1977

TYPE OF EMPLOYEE	1969 Number	1969 Percentage	1977 Number	1977 Percentage
Physicians	2	1.3	8	3.5
Dentist	-	-	1	0.4
Nurses:				
Primary Care Nurses	18	12.0	24	10.4
Registered Nurses	12	8.0	28	12.2
L.P.N.'s	1	0.6	4	1.7
Aides	13	8.6	25	10.9
SUB-TOTAL	(44)	(29.3)	(81)	(35.0)
Health Educator	-	-	1	0.4
Supportive:				
X-ray Technician	1	0.6	2	0.9
Lab Technician	-	-	5	2.1
Pharmacist	1	0.6	2	0.9
Social Worker	1	0.6	2	0.9
Physical Therapist	-	-	2	0.9
SUB-TOTAL	(3)	(2.0)	(13)	(5.7)
Business and Management:				
Management	7	4.6	17	7.4
Clerical	24	16.0	41	17.9
Medical Records	5	3.3	10	4.3
SUB-TOTAL	(36)	(24.0)	(68)	(29.6)
Maintenance, Diet & Housekeeping	65	43.0	55	24.0
TOTAL	150	100.0	227	100.0

YEAR	ADMIN.	HOSPITAL	P.C.C.	DISTRICT	HOME HEALTH*	ED. & RESEARCH
1969	21	56	36	30	--	7
1977	13	115	37	19	13	12

*Home Health became a separate agency in August 1976.

actual members and percentages. The other major change is the decrease in the maintenance, diet, and housekeeping personnel, which have decreased from a total of 65 to 55.

It should be noted that a new hospital was opened which increased beds from 26 to 40, and the admissions to the school have doubled. These were the two areas in which personnel doubled.

The proportionate decrease of primary care nurses among the health care staff from 36.7 to 23.3% of total staff indicates that they play a much lesser role in the provision of health care. Primary care nurses have been the most difficult to recruit and retain. Opportunities for employment in other geographic areas have increased and so has the salary. Furthermore their role at the FNS is no more as distinctive or as prominent as it used to be in relation to other staff.

Both service and education programs are constantly working toward development of a well organized system for the benefit of each. The full ramifications of a new service area are rarely recognized until such members are added to the staff. It has both advantages and disadvantages. The larger the staff the more impersonal the services and the interpersonal relationships.

d. Recruitment, Admission Criteria and Evaluation of Students:

1) Recruitment: Because of its long history of training in nurse-midwifery for rural health, the FNS did not have to make any special efforts to recruit students for the Family Nursing program. This was the least of the problems encountered. The FNS

always had more applicants than it could accept, it merely had to let applicants know of the changes in the education program. With the limited availability of secretarial help this was problem enough.

It should be noted that the FNS, from its inception, has always published a quarterly bulletin (distribution 4,000) that announces program developments and any changes. Staff also are frequently asked to speak and publish articles about its education and service programs. These requests have increased substantially with the growing recognition of primary care nursing in this country, as have the requests for state and national consultation and observation visits. This leads to many inquiries. The number of inquiries received has increased from an average of 200 to 300 a month since the Primex Grant was awarded. Both the Frontier Nursing Service Brochure (1977) and the School Catalogue (Appendix A) provide well rounded descriptions of the service and training programs. Either or both may be sent depending on the inquiry.

No formal advertising was necessary. Word of mouth is still considered the most effective recruitment device. Its graduates and students are its best advertisements. The FNS had graduated 350 nurse-midwives at the time the Family Nurse Program was initiated, and it has since admitted 179 students to the Family Nurse Program.

The FNS also has a volunteer program for couriers, usually college students who are interested in rural areas. They spend an average of six weeks with the FNS, performing selected tasks in the Service. Many later select a health career. They also contribute to the publicity of the program. They form donor committees in other cities, and participate on the Board of Governors.

2) Applicants:

When the program was initiated applicants were required to spend a minimum of four to six months on staff prior to admission into the program. Pre-admission employment had two major purposes:

1) It provided staff an opportunity to evaluate students prior to admission, thus keeping drop-outs to a minimum; and
2) It provided a means of staffing the service, at a time when recruitment to rural areas was difficult.

Occasionally students were admitted without the above requirements, when a last minute withdrawal occurred. This requirement for pre-admission employment was discontinued in 1977.

To be accepted for employment applicants were required to be eligible for nurse licensure in the Commonwealth of Kentucky, have three satisfactory letters of recommendation and a satisfactory medical report. The usual information regarding age, place of residence, sex, prior professional education and clinical experience was requested. If they were interested in the family nurse or nurse-midwifery program they were asked to fill out an additional form.

To be accepted for admission to the training program, applicants had to have:

1) A favorable clinical performance evaluation from staff who had observed them;
2) Have a favorable interview by members of the admission committee; and
3) Meet admission criteria as defined in the School Catalogue (Appendix A, p. 14)

Table III provides the educational background and age of the first 149 applicants between June 1970 and May 1974. It shows that 38, or 26%, withdrew their application during the pre-employment period; 5, or 3%, were rejected by the admissions committee; and 106, or 71% were accepted and admitted. All but 5 of those accepted, graduated from the program. This suggests that pre-admission employment was instrumental in maintaining a low drop-out rate.

The most outstanding point to be derived from the data is that neither age nor educational background seemed to be a significant factor in determining what applicants were most apt to enter the program after completing the application process, or which applicants would be rejected. The average age of applicants that withdrew and were rejected was 28 and 29 respectively and the average age of the applicants was 30. The age ranges also did not vary significantly. The age of the withdrawals ranged from 21-46, the rejections 20-42, and the admissions 21-56. The average age of those admitted was 32, and their age ranges were slightly higher, but they also formed the largest groups. Because of the small numbers involved,

TABLE III

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Number and Percentage of Applicants in the Primary Care Nursing Program
including Withdrawals, Rejections and Admissions
According to Educational Background and Age
June 1970 - May 1974

	Avg. Age	Age Range	AD		DIPLOMA		B.S.		M.S.		TOTAL	
			#	%	#	%	#	%	#	%	#	%
Withdrawals	28	21-46	4	40	18	22.4	13	31.0	3	18.7	38	26
Percentage			10.5		47.4		34.2		7.0		100	
Rejections	29	20-42	1	10	2	2.4	1	3.4	1	6.3	5	3
Percentage			20.0		40.0		20.0		20.0		100	
Admissions	32	21-56	5	50	61	76.2	28	66.6	12	75.0	106	71
Percentage			4.7		56.6		26.4		11.3		100	
Total No. of Applicants	30	20-56	10	100	81	100	42	100	16	100	149	100
Percentage			6.6		54.4		28.2		10.7		100	

the difference is not felt to be significant.

The distribution of educational background was very similar among the withdrawals, rejections and admissions. Eighty-one, or 54.4% of the applicants were diploma graduates, and 56.6% of those admitted were diploma graduates. Forty-two, or 28.2%, of the applicants were B.S. graduates, and 28 or 26.4% of those admitted were baccalaureate graduates. Sixteen, or 10.7% of the applicants were master's graduates and 12 or 11.3% of the admissions were master's graduates. Ten, or 6.6%, of the applicants were A.D. graduates and 5 or 4.7% of those admitted were A.D. graduates. The withdrawals and rejections of applicant from the different educational programs were similarly proportionate to their distribution among the applicants.

The A.D. and baccalaureate graduates had slightly higher withdrawal rates; the A.D. and Master's had slightly higher rejection rates. The total numbers of A.D. and Master's graduates were insufficient to draw significant conclusions from the difference in rates. The higher withdrawal rate among the baccalaureate graduates may well have been related to their desire to enter a University program to obtain graduate credits for the year long program of study.

The most frequent reasons given for withdrawal were the isolation and lack of cultural opportunities in the area, the degree of responsibility that the primary care nurses were expected to assume for patient care, and the desire to enter a program which would grant them academic credit. Many, after participating in the program and observing the primary care nurse first hand, changed their minds about entering the program for other reasons. Some decided to get married or raise a family, some dicided to change their careers (a factor to which they had given serious consideration before joining the FNS), some thought the program to difficult and others did not like either the program or the way it was managed. The reasons for withdrawal were almost as varied as the number of withdrawals. It should be noted that a high proportion of those that withdrew would have been rejected, but that others were considered excellent candidates.

All but one of the rejections were based on clinical incompetencies, e.g. lack of clinical judgment, inability to establish appropriate priorities, and/or lack of organizational abilities. One of the students that was rejected was encouraged to enter another program that permitted students to study at their own pace, in an area that offered more cultural opportunities. She successfully completed the program and is currently working in a rural area. She was a young A.D. graduate who it was thought would do better in another program.

After graduating the first hundred students the FNS decided to request educational transcripts from the applicants to assist in the selection, since many of the applicants mentioned their academic difficulties as one of the factors which influenced their decision to withdraw. Access to transcripts was found to be helpful in making choices between applicants when other factors appeared to be equal, and in counseling applicants that were marginal.

It should be noted that none of the applicants were rejected because of their personality or character traits. On the other hand, some of the students that withdrew were felt to have undesirable traits, e.g. lacking sensitivity in their management of patients, lacking in consideration of the cultural values of the people in the community, or demonstrated difficulties in their relationship with peers and persons in authority. Applicants that were perceived to have major problems in these areas were more apt to withdraw, primarily because they were unhappy in the situation.

It should be noted that pre-admission employment, while it had its advantages, also created problems. Tensions ran high when the time approached to make selections. Some students withdraw their application because they feared rejection. Others withdrew in order to leave room for someone else that they knew was very eager to enter. The selection process is often traumatic particularly when the competition is keen, and when the selectees are all part of a tightly knit community. It is difficult for applicants to see preference given to cohorts, with whom they have worked closely. It is equally difficult for the admission committee to make the selections when they know they will have to continue working with the applicants after the selection has been made.

One may therefore say that this system had both advantages and disadvantages; but until the new system is tried we cannot say which is most advantageous.

A most important lesson can be learned from this experiment. Applicants, given an opportunity to observe the primary care nurse in operation, are perhaps the best judges of their own ability and suitability for primary care nurse training. Given the opportunity for observation, self selection together with faculty participation, becomes a reliable and effective method for the identification of suitable applicants. It is not necessarily very practical, but it can serve a useful purpose in isolated rural areas. When primary care nursing becomes more prevalent, opportunities for observation will become more widespread.

The distribution of students from the different educational programs is tending to equalize itself. The ratio of applicants from diploma programs is declining; the applicants from collegiate programs is increasing. The applicants with Master's degrees have remained relatively stable. The last class to be admitted February 1977 had an equal distribution of each as noted in Table IV.

Sixteen of the accepted applicants were certified nurse-midwives (C.N.M.'s), two were pediatric nurse practitioners (P.N.P.'s), and two were certified registered nurse anaesthetists. Each had practiced in the extended role; and none of them withdrew from the program. Of the 10 that withdrew 2 held A.D., 2 held diploma; 2 held a Master's degree, and 4 held a baccalaureate degree. One of the diploma graduates withdrew because she did not believe

TABLE IV

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Number and Percentage of FNS Students Admitted and Withdrawn Prior to Graduation According to Year and Highest Degree Held June 1970 - February 1977

YEAR	NO. OF CLASSES	NUMBER ENTERED	ASSOCIATE DEGREE	DIPLOMA	BACCALAUREATE	MASTER'S
1970	2	6	-	6	-	-
1971	3	24	1	18	3	2
1972	3	29	1	14	11	3
1973	3	35	3	16	12	4
1974	2	24	1	8	11	4
1975	2	24	5	11	5	3
1976	2	25	6	9	9	1
1977	1	12	3	3	3	3
TOTAL	18	179	20	85	54	20
Percentages		100	11.2	47.5	30.1	11.2
Withdrawn		10	2	2	4	2
Percentages		5.6	10.0	2.4	7.4	10.0
OTHER CERTIFICATION						
C.N.M.		16	-	9	4	3
P.N.P.		2	-	-	-	2
C.R.N.A.		2	-	2	-	-

she was suited to the primary care nursing role, and returned to intensive care in the nursery. One Master's graduate withdrew because of illness; and one baccalaureate withdrew for personal reasons. All others withdrew because of academic and/or clinical difficulties. The ratio of applicant's who withdrew for academic and/or clinical reasons was highest for the associate degree graduates 10%; second highest for the baccalaureate graduates 5.5%; third highest for the Master's graduates 5%; and lowest for the diploma graduates 1.2%. Because of insufficient number of applicants from the three academic programs that withdrew for clinical/academic reasons, no significant conclusions may be drawn from the different ratios. However, because only one out of 85, or 1.2% of the diploma graduates withdrew for academic reasons, and 6 out of 94 or 6.4% of the collegiate graduates withdrew for academic/clinical reasons, the difference appears significant. Because the actual percentage (5.6%) of the withdrawals and the differences in the ratios of withdrawals from the different educational programs is so low, there is not sufficient evidence to discriminate among applicants solely on the basis of their academic background. There were no academic failures.

3) Distribution of Applicants Between Family Nursing and Nurse-Midwifery: The largest percentage of applicants want both the family nursing and the nurse-midwifery components of the Primary Care Nurse Training Program. It is, however, not uncommon for students to change their mind after completing the first or second trimester. Some may drop out for one or two trimesters to work, after

completing the first or second trimester and then continue with the program. According to Table V, 16 or 10% had completed nurse-midwifery training before they enrolled in the program and received their Family Nurse-Midwife certificate after completing Family Nursing I. An additional 86 or 56% took both Family Nursing and Nurse-Midwifery, making a total of 102 or 66% that graduated as Family Nurse-Midwives. Twenty or 13% completed Family Nursing I only and received a family nurse associate certificate. Eighteen or 11% completed Family Nursing I and II only and received Family Nurse Certificates. Two of the students currently enrolled expect to complete FN-IA, FN-II and FN-III only for a nurse-midwifery certificate. This option was first offered to applicants in October 1975. Nine or 6% withdrew in FN-I and 2 or 1% withdrew in FN-II. Both of those that withdrew in FN-II entered other nurse-midwifery programs to complete training in their chosen area.

The first fifteen classes or 133 graduates entered the program when it was only three trimesters long. This occurred before the "family nurse" component was divided into two trimesters. During this time the FNS offered:

a) family nurse associate certificates for applicants that completed the first trimester only;
b) family nurse certificates for those that completed the first two trimesters, (this included the prenatal, postpartum, family planning and neonatal components; and
c) family nurse-midwife certificate for those that completed all three trimesters.

TABLE V

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Students Admitted, Withdrawn, Graduated and Currently Enrolled in Primary Care Nursing Program from the First XVI Classes
June 1970 - February 1977

	FN-I*				FN-II			FN-III***		INTERNS
DATE CLASS	Ad.	Wd.	Gr.*	C.N.M.'s***	Ad.	Wd.	Gr**	Ad.	Gr.	
1st Year										
6-70 I	3	-	-	-	3	-	-	3	3	-
9-70 II	3	-	1	-	2	-	-	2	2	-
1-71 III	6	-	-	2	4	-	-	4	4	-
TOTAL	12		1	2	9			9	9	
2nd Year										
6-71 IV	8	-	1	1	6	-	1	5	5	-
10-71 V	10	-	2	1	7	1	1	5	5	-
2-72 VI	9	-	-	1	8	-	2	6	6	-
TOTAL	27		3	3	21	1	4	16	16	
3rd Year										
6-72 VII	10	-	3	1	6	-	1	5	5	-
10-72 VIII	10	1	2	2	5	-	1	4	4	-
2-73 IX	12	-	4	2	5	1	1	4	4	-
TOTAL	32	1	9	5	16	1	3	13	13	-
4th Year										
6-73 X	11	-	2	-	9	-	1	8	8	-
10-73 XI	12	2	1	1	8	-	1	6	7	-
2-74 XII	12	2	1	1	8	-	1	7	7	7
TOTAL	35	4	4	2	25		3	21	22	7
5th Year										
10-74 XIII	12	1	-	2	9	-	3	6	6	10
6-75 XIV	15	1	2	-	13 ①	-	3	9	9	11
TOTAL	27	2	2	2	22 ①		6	15	15	21
6th Year	FN-IA and FN-IB									
10-75 XV	9	-	1	1	7	-	-	7 ④	3	5
2-76 XVI	13	2	-	1	10 ④	-	2	4 ②	2	10 ⑥
TOTAL	22	2	1	2	17 ④		2	11 ⑥	5	15 ⑥
GRAND TOTAL	155	9	20	16	111 ⑤	2	18	86 ⑥	80	43 ⑥
PERCENTAGE	100	6	13	10	70	1	11	56		25

⊙ - Students Currently Enrolled. This does not include last two classes admitted.
* - Received Family Nurse Associate Certificates
** - Received Family Nurse Certificates
*** - Received Family Nurse-Midwifery Certificates
C.N.M's were certified as Nurse-Midwifes when they enrolled in the program.

Since the first trimester has been lengthened into two trimesters, the FNS no longer accepts applicants for the "family nurse associate" certificates only. This decision was made because of the requirements established by ANA for the National Examination for Family Nursing, which includes coverage of obstetrical and gynecological content.

Since the above change was made it should be noted that only four classes have been admitted. These applicants are just beginning to be graduated. So far an average of two applicants per class of twelve want family nursing only and two want nurse-midwifery only. This leaves 67% who plan to complete both Family Nursing and Nurse-Midwifery. This percentage has not changed.

4) Other Characteristics:

Most of the applicants are female. While several letters of inquiry have come from males, only one male has completed the application process. He is happily enrolled and doing well. He plans to complete the Family Nursing Program only.

Most of the applicants are from the caucasian race. Two applicants were American Indians. One withdrew but the other one successfully completed the program, and is now the first family nurse-midwife to be practicing in her own reservation. Only one black applicant applied and she withdrew before entering the program. Inquiries have been received from both Japanese and Chinese, but none have completed the application process.

While the majority of the students are single, the FNS has admitted widows, divorcees, wifes, mothers and grandmothers, a husband and a father. No preferences are made either on the basis of sex, race, marital status or parenthood. Nor have any studies been done on the above. This would have been considered discriminatory and these factors were considered insignificant. Age was considered a possible factor as was noted earlier. Its effect on scores will be presented later.

Students are required to have a minimum of one year experience before entering the class. No requirements were established, regarding the type of nursing experience that was required. Nor have any studies been done on the impact that the different types of nursing experience had on their performance. The range and types of experience were so broad that the different categories would have been either too vast and the numbers too small to reach any significant conclusions. Applicants had worked in every conceivable type of position including hospital administration, consultation, counseling, supervision, education (university, college, and diploma nursing as well as other teaching positions). They had worked in a wide range of clinical areas in nursing and in a wide range of settings. A relatively high percentage had experience in intensive care. Some had been nursing aides, others L.P.N.'s, and some had had non-nursing careers. Some had entered nursing in their youth and some after they had been widowed or divorced. Others had been in the armed services, or in the Peace Corps, and many had other foreign experience. Generally faculty and students enjoyed the broad range of experience represented in the class, as well as the freshness of the recent graduates. The mixture was considered an asset.

5) Admission Requirements:

The only admission requirements used throughout this study were:

a) clinical competency as determined by pre-admission evaluation of staff and three letters of recommendation;

b) eligibility for state licensure as a registered nurse;

c) satisfactory completion of a basic nursing program; and

d) a satisfactory medical report.

No preference was given to any of the educational programs from which they were graduated.

Selection for admission is based on the criteria and qualifications as presented in the School Catalogue (Appendix A, p. 14). The most difficult criteria to establish are the clinical and personal competencies and suitability. (See Below)

1) Reliability, thoroughness, efficiency and analytic sense in the performance of nursing functions;
2) Self-direction and constructive participation in staff and program development;
3) Relationship with patients, peers, ancillary staff, supervisors and physicians;
4) Suitability for work in a rural, economically deprived area which is conservative in outlook;
5) Suitability to undertake an educational program that is rigorous, demanding and service-oriented.

Both physicians and nurses are asked to evaluate prospective students. They are in full agreement about those with high or low recommendations. They are in less agreement about those that are borderline, i.e. those that demonstrated difficulties in establishing priorities or organizing their work and reports, but seemed enthusiastic and committed. The borderline group also have the greatest difficulty following admission. It is only the rare student that has difficulties in the beginning that later excells, and vice versa. Initial impressions gained through interview were generally lasting, but sometimes misleading.

The first two years there were no student withdrawals in family nursing when the admission committee was limited to three. During the last two years withdrawals were 10%. The larger the number of people on the admissions committee, the larger the number of withdrawals. On the other hand, faculty became happier when they became more involved in the decision-making. Senior students, at their request, are now also represent on the admissions committee. The broader involvement provides a more democratic procedure which creates fewer overall problems. It also helps students gain a better comprehension of the administrative problems involved. The process is considered a good learning experience for them. They will be the future faculty.

Application procedures and financial arrangements are discussed in the School Catalogue (Appendix A, p. 15-16). Admission procedures were jointly developed and approved by the service and education staff and administration, with student participation. These were established on the basis of need, availability of resources, experience and convenience or practicality. These are reviewed annually or biannually when the catalogue is revised.

6) Financial Arrangements:

Tuition is based on the level of tuition charged at the State

University with which affiliation is being sought. This was increased from $250 to $300 per trimester, two years ago, to meet the rise in costs. A $50 field fee was added to pay for the library books and audiovisual aides, when the FNS got its new library and audiovisual department. A non-refundable $50 registration fee was added when the school registrar had difficulty in managing the large number of individuals applying. This helped weed out those applicants that were not seriously considering enrollment.

Tuition has not been a major barrier since students may request a scholarship. A very small percentage accept scholarships, which require an equivalent employment commitment after graduation. Applicants seem much less hesitant to accept a post graduate employment commitment when it is not tied to a monetary contract. Few applicants have objected to the one year employment commitment that is now required. Students strongly supported this requirement when it was proposed.

7) Faculty Preferences:

Generally nurse-midwifery faculty prefer applicants who have had recent clinical experience in obstetrical nursing, but who have not yet become "set in their ways". Family nurses prefer applicants who have had recent general nursing experience which includes care and management of the physically ill patient. Public health, psychiatric nursing, emergency room experience, intensive care, and anaesthesia are all considered helpful. For that matter any nursing experience including administration and education is valuable. For family nursing any other experience that has broadened the applicant's comprehension of life and its wide vicissitudes of problems and options, the resiliency of the human body and mind, and its responsiveness to the human touch is important. They are qualities that develop through experience if the mind is open. They do not lend themselves readily to technological measurements. Nor are they apportioned or always consistent. There is, however, a high degree of agreement among observers regarding their presence or absence, and their desirability.

Faculty have agreed not to change the one year work requirement. Most applicants have more experience; and the admission committee has the option of postponing the time of acceptance.

The FNS did not look at prior theoretical performance as a base for selection of the first hundred graduates. Some students were accepted who admittedly had experienced difficulties in learning, and who had failed in their initial state boards, as long as their clinical performance was considered satisfactory. Three students who had symptoms of dyslexia were accepted. All had to work exceedingly hard, but they were unusually sensitive in their relationship to others and they were dependable. They are doing well, and are highly appreciated by both their cohorts and patients. Some Phi Beta Kapa's who have been accepted have had greater difficulties in their relationship with others and in the decision-making process. Generally, students who have previously demonstrated minimal learning difficulties in the past will not have difficulty in this program, unless they are under stress due to unrelated factors. These matters are highly individualized. High academic scores for these reasons, while they may facilitate learning, are not considered essential, nor necessarily preferable. Students who have recently been enrolled in an academic program or engaged in continuing education generally find the mastery of theoretical content less difficult.

Faculty believe that the majority of students who have met licensure requirements and have the required clinical experience, can successfully complete the primary care nursing program if they are sufficiently motivated. Some students however are more suitable than others. Applicants are told that the program is difficult, the course work intensive, and that they will be required to work hard.

8) Present Admission Procedures:

The Admission Committee gives the applicant an overall rating based on admission criteria, educational and work experience and personal interview reports. Interviews are conducted over a three day period in which applicants have an opportunity to observe and participate in the FNS service and education program. This gives them an opportunity to observe the program and react to it in the interview. This also provides feedback to the Admissions Committee by the interviewers.

Applicants with the highest rating are accepted. For the next class the FNS has thirty-two applicants who have completed the application process. Only twelve students can be admitted. Others will be placed on a list of alternates. They may keep their name on file for the next class to compete with new applicants. Applicants that are accepted must join the FNS for one month's orientation prior to enrollment. During this period they may withdraw, or be counseled to withdraw, but they are guaranteed admission.

This procedure has evolved out of six years experience. It still needs testing to determine its practicality. It requires considerable input of costs, time and effort from the applicants, the service agency and the educational staff. It is, however, considered a necessary procedure for appropriate selection of the students at this time.

The aim is to maintain a balance between advantages and disadvantages, to keep the number of withdrawals and the less suitable students at a minimum, to reduce the costs of student selection, the stress, and the inconvenience associated with failure in performance or withdrawal, and finally to assure the quality of the graduates.

9) Student Evaluation:

The student evaluation methodology, like the curriculum evaluation, was empirical. Students are given both clinical and theory grades according to their performances. Clinical grades are based on their performance in the clinical setting. A relatively objective way of doing a weekly record audit has been established. This audit provides immediate feedback to the student, using Weeds method of audit based on the problem-oriented record. Midterm and final evaluation of students are more subjective with input from all clinical instructors, both primary care nurses and primary care physicians. This has gradually evolved with the introduction of the problem-oriented record. Theory grades are given by their classroom instructors on the basis of written tests, oral tests, class participation and written papers. Careful records were kept of both the clinical and theory grades, according to age, place of residence, prior clinical experience, and educational background, together with place of employment upon graduation. Two questionnaires have been mailed to graduates to up-date deployment data.

Table VI indicates relationship between age and grades. The grade point averages do not correspond significantly with age. Four students were 50 years of age and over; five students had "C's". The numbers are so small, no conclusions can be drawn from the distribution. However, it should be noted the grade point averages in both theory and clinical performance tend to follow a curve. Students reached their peak performance between ages 25-29 in theory, with a grade point average of 3.49; and between ages 30-39 in clinical practice, with a grade point average of 3.53. Theoretical performance does not follow a distinct curve as does clinical performance indicating that ability to master theory is less related to age than is clinical performance.

Table VII indicates the relationship between theory and clinical performance and prior experience in a foreign country. It can be surmized that applicants who had worked in foreign countries had assumed greater responsibility for primary care functions, prior to enrollment and might therefore have higher grade point

TABLE VI

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Performance in Theory and Clinical Grades According To Age Of First 133 Students Completing Family Nursing Program June 1971 - April 1976

			AGE 20-24	AGE 25-29	AGE 30-39	AGE 40-49	AGE 50 & Over	TOTAL	
A	THEORY	#	13	23	8	7	1	52	
		%	25%	44%	15%	14%	2%	39%	
	CLINICAL	#	12	22	18	10	-	62	
		%	19%	35%	29%	17%	-	47%	
B	THEORY	#	17	21	19	13	3	73	3 Incomplete=2%
		%	23%	29%	26%	18%	4%	55%	
	CLINICAL	#	19	23	10	11	3	66	
		%	29%	35%	15%	16%	5%	50%	
C	THEORY	#	1	1	2	1	-	5	
		%	20%	20%	40%	20%	-	4%	
	CLINICAL	#	1	-	2	1	1	5	
		%	20%	-	40%	20%	20%	3%	
TOTAL NO. OF STUDENTS			32 24%	45 33%	30 23%	22 17%	4 3%	133	
AVERAGE GRADE IN THEORY			3.39	3.49	3.21	3.29	3.25		
AVERAGE GRADE IN CLINICAL			3.34	3.49	3.53	3.41	2.75		

TABLE VII

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Performance in Clinical and Theory Grades According to Prior
Foreign Experience of First 133 Students Completing Family Nursing Program
June 1971 - April 1976

		A	B	C	TOTAL	AVERAGE GRADE
FOREIGN EXPERIENCE	THEORY #	15	25	1	41 1 Incomplete	3.34
	%	37%	61%	2%	100%	
	CLINICAL #	21	19	2	42	3.40
	%	50%	45%	5%	100%	
ALL OTHERS	THEORY #	38	47	4	89 2 Incomplete	3.38
	%	43%	53%	4%	100%	
	CLINICAL #	41	47	3	91	3.42
	%	45%	52%	3%	100%	
TOTAL OF THEORY		53	72	5	133	
TOTAL OF CLINICAL		62	66	5	133	

averages in the clinical area. The difference was very slight. Fifty percent of those with foreign experience had A's and 45% had B's in clinical practice while among those without foreign experience 45% had A's and 52% had B's. The theoretical performance was slightly lower for those with foreign experience. Again, the numbers are too small to draw any definite conclusions from the findings.

As noted in Table VIII, range in years of experience was wide, from 1 to 28 years. Forty-one or 26.1% had one year experience; 44 or 28% had 2-4 years experience; 34 or 21.7% had 5-9 years experience; and, 38 or 24.2% had 10 or more years experience. The A.D.'s had the least experience as a group, and the Master's the most. The Diploma graduates were fairly equally distributed.

Table IX and X which show the differences in educational background indicate only a slight difference between theory and clinical grades according to educational background. Average grade point averages for theory were 3.33 for A.D.'s; 3.38 for Diploma graduates; 3.36 for baccalaureate; and 3.46 for the Master's graduates, as noted in Table IX. A greater variation was noted in the grade point average in the clinical area: A.D.'s had a 3.2 grade point average; Diploma a 3.44 average; Baccalaureate graduates a 3.41 average; and Master's a 3.8 average, as noted in Table X.

These tables also show the relationship between years of experience and educational background in both theory and clinical grades. Students with only one year experience tended to have

TABLE VIII

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Average Nursing Years Experience Prior To
Admission According to Highest Degree Held
June 1970 - February 1977

NO. OF YEARS	A.D.	DIPLOMA	B.S.	M.S.	TOTAL	
					Number	Percentage
1	9	18	14	--	41	26.1
2-4	4	22	14	4	44	28.0
5-9	2	19	11	2	34	21.7
10+	--	22	7	9	38	24.2
TOTAL	15	81	46	15	157	100.0

TABLE IX

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Average Theory Grade Point Average According
to Years Experience and Highest Degree Held
Prior to Admission
June 1970 - February 1977

YEARS	A.D.	DIPLOMA	B.S.	M.S.	TOTAL GR.PT.	AVERAGE
1	3.1 (9)	3.44 (18)	3.28 (14)	---	136 (41)	3.31
2-4	3.75(4)	3.45 (22)	3.5 (14)	3.7 (4)	157 (44)	3.56
5-9	3.5 (2)	3.26 (19)	3.18 (11)	4.0 (2)	112 (34)	3.29
10+	---	3.36 (22)	3.28 (7)	3.2 (9)	126 (38)	3.31
TOTAL GR.PT.	50 (15)	274 (81)	155 (46)	52 (15)	531 (157)	
GR.PT. AVERAGE	3.33	3.38	3.36	3.46		3.38

( ) Number of Students

TABLE X

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Average Clinical Grade Point Average According
to Number of Years Nursing Experience Prior
to Admission and Highest Degree Held
June 1970 - February 1977

YEARS	A.D.	DIPLOMA	B.S.	M.S.	TOTAL GR. PT.	AVERAGE
1	3.10 (9)	3.44 (18)	3.35 (14)	---	137 (41)	3.34
2-4	3.50 (4)	3.50 (22)	3.57 (14)	4.0 (4)	157 (44)	3.56
5-9	3.0 (2)	3.52 (19)	3.27 (11)	4.0 (2)	117 (34)	3.44
10+	---	3.36 (22)	3.40 (7)	3.66(9)	130 (38)	3.41
TOTAL GR.PT.	48 (15)	279 (81)	157 (46)	57 (15)	541 (157)	
GR.PT. AVERAGE	3.2	3.44	3.41	3.8		3.44

( ) Number of Students

lower scores than those with 2-4 years of experience. After that it was difficult to identify any pattern.

Students who had "C's" in theory and clinical experience showed less evidence of continuing education or increased job responsibility, as evidenced by a review of the educational background and work experience of those with a "C" grade.

A review of the students employment pattern prior to admission into the program according to average length of stay on the job provided the most striking indicator. Students who tended to stay on jobs an average of 2-3 years had higher scores in the clinical area, than those who tended to spend less time on the job as noted in Table XI. A slight decline was noted for those spending longer time on the job which may not be valid because this included several C students who had remained on the same job ten years or longer without evidence of continuing education or increased job responsibility. Students who had spent an average of 12 months or less on a job had the lowest grade point average. This included those students who had only one year experience. Only 33% of these students had A's; while 45% of those students who spent an average of 13-24 months on a job had A's; and 66% of those who spent an average of 25-36 months on a job had A's. The same pattern was not noted in the theoretical performance.

A review of the educational and clinical background of the student body showed a preponderance of students with strong evidence of continuing education activities which were difficult

TABLE XI

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Theory and Clinical Grades According to Prior Professional
Employment Patterns of First 133 Students
Completing Family Nursing Program
June 1971 - April 1976

MONTHS			A	B	C	TOTAL	AVERAGE GRADES
0-12	THEORY	#	14	21	--	35	3.4
		%	40	60	--		
	CLINICAL	#	12	23	1	36	3.3
		%	33	64	3		
13-24	THEORY	#	18	17	3	38	3.39
		%	47	45	8		
	CLINICAL	#	17	20	1	38	3.42
		%	45	53	2		
25-36	THEORY	#	7	12	2	21	3.23
		%	33	57	10		
	CLINICAL	#	12	7	1	20	3.55
		%	60	35	5		
37-	THEORY	#	14	22	--	36	3.38
		%	39	61	--		
	CLINICAL	#	21	16	2	39	3.48
		%	54	41	5		
TOTAL OF THEORY		#	53	72	5	130 (plus 3 incomp.)	3.36
		%	41	55	4		
TOTAL OF CLINICAL		#	62	66	5	133	3.43
		%	47	49	4		

to categorize. Also noted was a tendency to assume increasing responsibility in nursing as evidenced by a vast array of nursing experience in intensive care units, foreign work, teaching, community activities, supervision and/or administration. Because of the difficulty in categorizing the above and the small numbers involved in each category no tables were developed to portray this evidence. It should be noted however that preference was given to students with well rounded nursing experience, who showed evidence of having assumed high levels of professional responsibility. Generally these were the people who had tended to spend at an average of at least 2-3 years on a job.

Students with one to two years experience cannot be selected on the basis of previous patterns of employment. If observed at work it is not difficult to differentiate between those who are ready and able to assume increasing responsibility. Only the unusual student with less than two years experience can compete on an equal level with those students that have two or more years experience. Surprizingly, diploma graduates with less than two years experience were the least handicapped in both theory and clinical performance in this group.

It should be noted that little attention is drawn to the educational background of the students in the program. Faculty are rarely aware of the educational background of the A.D., diploma and baccalaureate graduates. They are more aware of the Master's graduates. Master's graduates tend to be more concerned with their level of performance, and have greater self expectations.

They seem to have as much difficulty in mastering the content as other students. They state that they are expected to master more technology in family nursing, than is expected in most nursing programs at the Master's level.

Generally the Master's graduate can be said to bring a new dimension to the program, depending on their majors. These have varied widely and include the four major clinical areas in nursing, nurse-midwifery, and pediatric nurse practitioners, with minors in education, administration and clinical practice. In addition, they have had Master's degrees in hospital administration, counseling and social work. These are all complimentary to family nursing; they are not replications of it. Family nursing is a new area of expertise for all, which requires new knowledge and new skill. Master's graduates appear to conceptualize with greater ease and be more adept at handling abstract ideas. At the same time, Master's graduates, because of their strong motivation and goal orientation, are excellent potential for leadership positions.

10) Deployment Patterns:

The deployment study is based on two questionnaires. One was sent to the first hundred graduates who graduated prior to 1975, and a second questionnarie was sent to all graduates in April 1976. The data from the second questionnaire was used to supplement the data from the first questionnaire.

The study of the professional deployment patterns of students indicates that graduates tend to follow the same pattern of deployment upon graduation that they developed prior to admission. Students that had spent less than four months at the FNS prior to enrollment spent an average of 4.7 months on FNS staff after graduation. Those that had spent over a year with the FNS prior to their enrollment had spent an average of 9.5 months on FNS staff following graduation at the time of this study as noted in Table XII. Several of these are still on FNS staff.

Table XIII indicates that 35% of the graduates of the first hundred graduates were sponsored by other agencies. These include a contract to accept up to two students per class from Tennessee. The FNS also has a policy to accept one student on foreign assignment per class. In addition it has accepted students sponsored by various Community Health Agencies, Virginia State Health Department, private physicians and group practices. Forty-six or 70% of the 66 non-sponsored students remained on FNS staff upon graduation for varying periods of time. Nine of these are still on FNS staff. Each has been on staff 3-6 years, since graduating from the program. The FNS has three additional graduates on staff that graduated since 1974.

Students that were sponsored all returned to the sponsoring agency to the best of our knowledge to complete their contract. The majority were sponsored for a period of 2-4 years. At no time has the FNS promoted students sponsored by other agencies, except when other agencies requested graduates, and were told that the best way to obtain staff was to sponsor students.

TABLE XII

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Average Length of Employment of Non-Sponsored Graduates
on FNS Staff Compared with Length of Pre-Admission Employment
June 1970 - May 1974

	NON-SPONSORED GRADUATES			TOTAL	
	Employed upon Comp.		Left upon Completion		
No. of Months Pre-Training Employment	No. of Graduates	Average No. of Months Emp. Post Grad.	No. of Graduates	No. of Graduates	Average No. of Months Employed Post Graduation
0-4	18	7.5	10	28	4.7
5-8	14	8.5	5	19	6.4
9-12	7	9.0	2	9	7.0
12+	7	12.2	2	9	9.5
TOTAL	46	9	19	65	7
PERCENTAGE	64%		36%	100%	

TABLE XIII

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Classification of First 100 Graduates
According to Sponsorship
June 1970 - May 1974

	Sponsored Graduates		Non-Sponsored Graduates				TOTAL
			Graduates who stayed on staff		Graduates who left upon graduation		
	No.	%	No.	%	No.	%	
1st Year	2	18	4	36	5	45	11
2nd Year	5	18	18	66	4	14	27
3rd Year	13	41	10	32	8	25	31
4th Year	15	48	14	45	2	6	31
TOTAL	35	35%	46	46%	19	19%	100

The most significant finding of the study was the deployment according to the type of population served; rural, urban, and inner-city. Table XIV shows that 67 or 82% of the 82 respondents held or had held positions in rural areas, and 21% in inner-city areas. Twenty-eight, or 33% moved to different locations during the time period studied; and 35 or 41% had held more than one assignment in the same agency or institution. For example, a graduate might be assigned to a staff and teaching position, or supervision and teaching, or have changed assignments from a staff to a supervisory and/or teaching position within the same agency. These studies indicate that the graduates of the program are relatively mobile. While 36, or 46% had held only one position, 25, or 31% had held 2 different positions, 12 or 15% had held 3 or more positions and 7 held four positions. It should be noted that this included 16 graduates that held only temporary employment at the FNS while they got additional experience or were seeking more permanent employment.

Several of the graduates that held positions in the urban areas were nurse-midwives who accepted temporary experience in big medical centers, to gain experience for working in the more rural areas, or who had accepted permanent staff positions in teaching centers.

Table XV shows what region of the country students come from and where they returned to after graduation. Of the 146 students involved in this study, 32 were still enrolled in the program at the time of the study. The highest percentage 107 or 73% came from the northern states. The majority 62 or 42.5% came from the

TABLE XIV
DEPLOYMENT PATTERNS OF 82 FNS GRADUATES IN RURAL, URBAN AND INNER CITY AREAS

June 1971 - April 1976

			RURAL + (rural & urban)				URBAN				INNER CITY (Including Overseas)			
DEGREE	TOTAL NO.	TOTAL NO. GRAD. RES.	STAFF	SUPER.	TEACH	NO. OF RESPONSE	STAFF	SUPER.	TEACH.	NO. OF RESPONSE	STAFF	SUPER.	TEACH	NO. OF RESPONSE
AD	4	4	3	2	2	2 75%	1	-	-	1 25%	1	-	-	1 25%
DIPL.	57	46	45	17	19	38 83%	12	1	1	12 26%	9	-	-	9 20%
BS	29	26	14	11	8	21 81%	8	4	-	11 42%	6	-	-	6 23%
MS	10	6	5	2	1	5 83%	-	-	2	2 33%	1	-	1	1 10%
TOTAL	100	82	67	32	30	67 82%	21	5	3	26 32%	17	-	1	17 21%

No. of graduates that changed location: 28 or 33%

No. of graduates that held more than one assignment per positio : 35 or 41%

CHANGE OF ASSIGNMENTS OR AGENCIES (including Frontier Nursing Service

Job #1	Job #2	Job #3	Job #4	
38 46%	25 31%	12 15%	7 8%	

36 or 46% of the 82 respondents held a Frontier Nursing Service assignment during the period studied.

TABLE XV

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Regional Deployment of Graduates Compared
to State or Country of Origin of Student
June 1970 - April 1976

STATE OR COUNTRY	ORIGIN OF STUDENTS		DEPLOYMENT OF GRADUATES	
	No.	Percentage	No.	Percentage
N.E. States	62	42.5	19	18.3
N.C. States	33	22.6	5	4.8
N.W. States	12	8.2	3	2.9
S.E. States	9	6.2	13	12.5
S.C. States	8	5.4	1	.9
S.W. States	7	4.8	13	12.5
Kentucky	7	4.8	29**	27.9
Foreign	8	5.4	21	20.2
TOTAL	146*	100.0	104	100.0

* 32 of the students were still enrolled in the program at the time of the study.

**20 of the graduates were on FNS staff.

northeastern states; only 19 or 18.3% of the graduates returned to these states. Of the 104 that had graduated, the majority 29 or 27.9% remained in Kentucky. Only 7 or 4.8% had originally come from Kentucky. Eight of 5.4% came from foreign countries and 21 or 20.2% of the graduates went to foreign countries. Only 24 or 16% of the students came from the southern states, and 27 or 25.9% of the graduates went to the southern states. The majority of the graduates went to the following geographic areas, Kentucky, foreign countries, the southwestern and the southeastern states, in that order.

It should however be noted that 52 or 35.6% had held foreign assignments prior to their enrollment in the program, and at the time of the study only 20 or 21% had returned to foreign assignments. Only 59 or 56% returned to their State or Country of origin. This indicates that the graduates are a relatively mobile group. It should be noted that this study indicates only the place of employment at the time of the study. A high percentage of graduates had held positions in more than one state or country.

It is significant that the majority, 82% of the graduates, sought rural employment for which they were trained; and a high percentage of the graduates migrated to medically underserved areas. For example 73.3% came from the northern states and only 25.9% returned to these states.

11) Summary of Student Evaluation and Deployment Studies:

On the basis of these findings one may conclude that nursing experience has a greater impact on student performance than did the basic educational background, and that individual commitment and motivations as demonstrated by continuing education practices and employment patterns following basic education are significant factors in predicting student performance. One may also conclude that training in a rural area has a profound impact on the deployment of the graduates. This may be related in part to the type of program in which students sought their training, but not entirely. Many students come to the FNS not because of their preference for rural areas, but learn to their great amazement that rural health care can be very exciting and challenging.

Unfortunately the FNS was not able to study the changes in attitude created through rural health training, because of the amount of time involved. On the other hand one is constantly bombarded with statements regarding the impact of this program on the personal lives of the students and their attitude towards others. This is created largely through intimate exposure to a vastly different cultural group; and through participation in a health care system which recognizes and supports their role as primary health workers. This is further reinforced by the practical approach to health care specifically designed to maximize their nursing care skills, in coordination with their newly learned primary care capabilities. Furthermore, the FNS is a relatively small health care agency that prides itself on its decentralized personalized approach to health care. This approach becomes increasingly difficult to maintain as the proportion of professional staff increases.

2. Development of Methodology for Assessing Health Services & Findings: Much time and effort was put into the development of a data collection system, which would provide the greatest potential for retrieval of statistical data with the least amount of paper work; interfere as little as possible with patient care management; and protect the privacy of the individual. The FNS since its inception had collected data on all patients seen. In the beginning all data collection was done by longhand with carefully planned data sheets. In 1968, the McBee card was initiated. In 1973 computer programming was introduced. The Professional Activity Studies and Medical Audit Program (PAS MAP) system for collection of hospital data was introduced in 1971.

The same patient I.D. numbers have been used since 1966, and are used in the district (home and clinics) and in the hospital (inpatient and primary care clinic). This permits longitudinal studies of health care utilization and outcome studies.

Medical Directives:

The FNS has also used medical protocol (1972 and 1975) since its inception which permits study of standards of care in effect at a given time and also provides a base for auditing quality of service in accordance with established protocol. These protocol are followed by all staff. Physicians may change preferred method of treatment if the patient does not respond to the prescribed protocol. Nurses must call the physician before initiating change. This system helps assure continuity of care and enables the team to function more effectively when more than one person is involved in the care of a given individual. The continuity is in the system rather than the individual. This becomes essential when more than one practitioner provides care to a given individual and when turnover in personnel is rapid. Protocols are revised every 2-3 years to keep them up to date. They are mutually developed by nursing and medicine. Specialist are consulted according to areas, and the pharmacy reviews and approves all drug usages. The format for the protocol is kept simple and focuses primarily on medical functions as compared to nursing functions. Nurses must sign a statement stating they will abide by the protocol, and physicians must sign a statement stating that they will give support to the nurse if she abides by the protocol. These statements are signed upon employment within the FNS.

The Encounter Form:

The FNS has spent considerable time in developing an encounter form (E-Form) for data collection. This data form is used for several purposes: a) for billing; b) for collecting statistical data for administrative and health care planning; c) for research purposes; d) for patient receipt and appointment; and e) for record keeping. The multi-purpose use of the encounter form was designed to cut down on excessive paperwork. (Appendix I)

Changes have been made in the encounter form annually. The aim is to keep these changes at a minimum to avoid confusion in a) filling out the form, b) data collection, c) computer programming and d) in the interpretation of findings. Each of the above factors is vital.

Reasons for change vary. In the beginning major changes were made in an effort to select data that were pertinent for purposes of billing, accounting, data collection and research activities. More recent changes have been initiated because of administrative changes in programming and billing. The latest proposed change will be initiated to accomodate Medicare/Medicaid billing for the primary care nurse according to the Medicaid/Medicare Billing System.

The encounter forms when initiated were considered a nuisance by the providers. The staff are currently more aware of its purposes and value and are less resistant. The biggest problem in its use centers around the accuracy of the data recorded. Administration is seriously considering the inclusion of the encounter form as part of the permanent record. This would reduce the paperwork, and thereby create less discrepancy between the billing and the recording of serviced provided. The latter is particularly important for record audits. It will also reduce some of the repetitiveness currently required.

The most recent form includes, more options for identifying health assessments, and types of counseling and instruction provided: a) preventive; b) maintenance; and c) curative; and the type of therapeutic care provided. The earlier forms focused more on medical functions. The new data areas were selected to permit identification of type of teaching and counseling and the type of nursing care provided, for purposes of research and reimbursement. There is increased interest in preventive and maintenance care and in instruction and counseling as this affects health care outcomes. Furthermore, both State and Federal agencies are contemplating reimbursement for preventive and maintenance care.

Other factors included in the E-Form are the assessments of health practices and counseling or instruction as related to health practices. These are functions that are considered vital to health care outcomes, but have rarely been recognized as pertinent health care services. Breslow (1972), Lalonde (1974), Levin (1975), and Rosen (1976), indicate that they have a more profound effect on the health status and longevity than does the treatment of illness. For these reasons they were included in an attempt to begin measuring input and eventually outcome. It should be noted that the E-Forms provide a mechanism for measuring quantity rather than quality.

Other problems encountered are related to interpretation of terms. One of the major problems of interpretation centers around the differentiation between preventive, maintenance and curative care, and counseling. Much effort was put into clarification of definitions that would result in uniform interpretations. (Appendix H for definitions) These definitions conform with reimbursement regulations, and provide a more accurate portrayal of the type of services provided.

It should be noted however that the lines of distinction between preventive and maintenance, and between maintenance and curative are often vague and relative, and for this reason they can never by exact. The point at which a consumer or provider defines a situation as problematic varies markedly when the situation is borderline. But since these terms are used as a basis for 1) reimbursement; 2) health care planning; and 3) rendering service, attempts must be made to clarify them in a meaningful manner.

This situation is complicated for two reasons. First preventive and maintenance care are not reimburseable, e.g. through Medicaid/Medicare. Secondly, the FNS does not charge for preventive services. Thus there is a tendency to identify problems as curative when actually they are preventive or maintenance. This is particularly prevalent when families have limited means for payment. If Medicare/Medicaid will foot the bill, the health provider is more apt to identify the problem as curative. This complicates the possibility of obtaining accurate encounter data.

a. Productivity and Accessibility:

1) Visits According to Age and Location:

Productivity and accessibility refers to numbers and types of visits and the availability of health services provided by the different providers. Table XVI indicates the distribution of care according to age and sex, according to the population groups served in 1974 and 1976. This table indicates that care is distributed fairly equitably with infants under one year and individuals sixty-five and over receive the greater

TABLE XVI

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Number and Percent of Visit
According to Age and Location
August 1974 and August 1976

	AGE				TOTAL NUMBER	PERCENTAGE
	Under 1	1-15	16-64	65 +		
Year 1974						
Home	70	153	483	495	1201	27.9
P.C. Health Clinic	100	488	647	35	1270	29.5
P.C. Med. Center	110	488	1098	132	1828	42.5
TOTAL PERCENTAGE	280 6.5	1129 26.3	2228 51.8	662 15.4	4299	100.0
Year 1976						
Home	15	50	324	452	841	15.1
P.C. Health Clinic	82	922	746	86	1836	33.1
P.C. Med. Center	162	734	1797	187	2880	51.8
TOTAL PERCENTAGE	259 4.8	1706 30.7	2867 51.5	725 13.0	5557	100.0
Population distribution of Leslie Co.*	1.8	34.4 (1-14)	56.4 (15-64)	4.8	100.0	

*Selected Vital Statistics and Planning Data;
Department of Human Resources, Division for Reserach and Special Projects, Kentucky, 1974

percentage of visits per individual.

Major shifts however can be noted between 1974 and 1976 with declines in Home and Primary Care Health Clinic (P.C.H.C.)* visits, and increases in the Primary Care Medical Center (P.C.M.C.)** visits. During the Primex Period, no mechanisms were available for the reimbursement of Medicare and Medicaid patients in the P.C.H. Clinics unless a physician was present. This had a major impact on the services offered. Three P.C.H. Clinics were closed during 1976 and one new primary care health clinic was opened. This was an administrative decision for financial reasons. Currently, six clinics are still in operation.

While many patients continue to seek care at the P.C.H. Clinics even though their care would be covered through third party billing at the P.C.M. Center, others seek care at the P.C.M. Center to secure this coverage. The P.C.H. Clinics are conducted by primary care nurses with a physician present one day a week. It should be noted that reimbursement regulations as a consequence have artificially skewed the data. They have markedly influenced the site where patients seek care, as well as the services offered. This should be considered in the review of the productivity and accessibility data presented.

With the reduction in the number of P.C.H. Clinics, the greatest reduction of visits has occurred among infants under one

*P.C.H. Clinics refers to the District Nursing Clinic
**P.C.M. Center refers to the O.P.D. of the Mary Breckinridge Hospital (M.B.H.), which is licensed as a Primary Care Center

and in the sixty-five and over age group. These are the two groups that have traditionally received the greater proportion of visits through the P.C.H. Clinics. They are frequently considered the most vulnerable age groups. The infants under one year are the most responsive to preventive care; and individuals 65 years and over are in the greatest need of maintenance care. This change coincided with several events: 1) the opening of the new Mary Breckinridge Hospital (M.B.H.) and the P.C.M. Center in 1975; and 2) an increase in charges for P.C.H. Clinic and home visits. The latter was necessary to meet increasing costs of care.

2) Hospitalization in Relation to Number of Visits and Age: Table XVII shows the increase in hospitalization which occurred following the opening of the new hospital. Without further studies these increases cannot be attributed to a decrease in the number of home and P.C.H. Clinic visits. However, it is significant to note that the greatest increase in admissions occurred in the 15 and under age group where the greatest decrease in visits occurred.

Hospitalization of the sixty-five and over age group continues to be well below the national hospitalization for this age group. Only 13.4% of the M.B.H. admissions are for this age group, whereas 18.6% of the admissions were for this age group in PAS hospitals in the United States in 1972-73. Average stay at the FNS remained at 5.03 days while the average for the other hospitals for this age group was 12.7 days. Furthermore, the FNS built the 40 bed hospital (per 15,000 population base) under the advice and specifications

TABLE XVII

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Number of Admissions at the
Mary Breckinridge Hospital by Age
1974 - 1976

No. Admissions For Year	AGE		AGE		AGE		TOTAL ADMISSIONS	
	0 —	15 yrs	16 —	64 yrs	65	+ yrs		
1974								
January - June	221*	123**	411*	269**	112*	0	744	504
July - December	201	100	400	266	112	0	672	437
SUB-TOTAL	422	223	811	535	224	0	1416	941
1975								
January - June	263	153	421	278	109	0	793	540
July - December	251	105	496	298	96	0	843	499
SUB-TOTAL	514	258	917	576	205	0	1636	1039
Percentage Increase	19.4	15.7	13.	.18	-8.4	0	15.5	10.4
1976								
January - June	300	143	472	272	122	0	894	536
July - December	265	145	525	325	120	0	900	590
SUB-TOTAL	565	288	997	597	242	0	1794	1126
Percentage Increase	9.9	.3	8.7	3.6	18.0	0	9.6	8.3
PERCENTAGE INCREASE FROM 1974 - 1976	33.8	29.1	22.9	11.5	8.0	0	19.6	19.6

*Grand Total

**Total Except Newborn, Maternity

of State and Federal agencies, this was also based on a market study by Booz Allen Hamilton (1969). Despite the market prediction of 70% occupancy in two years, the M.B.H. has had difficulty maintaining a 50% occupancy rate two years later.

This indicates a very low hospitalization rate for the population served. This was confirmed by a study of the diabetic patients served which indicated a reduction of 70% in hospitalization. While it is difficult to attribute the low hospitalization rate directly to the provision of primary health care through the home, the P.C.H. Clinics and the P.C.M. Center, this would seem a reasonable assumption.

Further studies are therefore needed to determine the cause of the subsequent increase in hospitalization. This may be partly attributed to the larger clientele served. Of the 11.4% increase in maternity patients, as noted in Table XVII, one third now come from outlying areas, from families seeking midwifery services. Families travel up to 200 miles for these services. There has also been a gradual increase in the population base of the community served in the past decade. In addition, the FNS has increased the services available. It has a wider range of medical specialists, better lab and x-ray facilities, a dentist, and a physical therapist. The FNS currently has on its staff: an obstetrician, a pediatrician, a surgeon, an internist, two board certified family physicians, and a generalist. The director, who has a M.P.H., is also a surgeon and obstetrician. All of this has markedly increased the medical services locally available, both in type and quality, and lessened the need for referrals to the Medical Center in Lexington. When the first grant was written for the training program, the FNS had one family physician, who was in the process of writing her family practice boards.

3) Number of Visits According to Type of Provider:

Unfortunately the FNS did not collect data on number and percentage of patients seen by the physician until 1974. At that time the FNS had four physicians on its staff. It is interesting therefore to note in Table XVIII that neither the number nor percentage of patients seen by the physician has increased in the twenty leading diagnostic categories. At the same time both the number and percentage of patients seen by the primary care nurse have increased. Indications are that physicians take more time to see individual patients, that they work less overtime and spend more time in teaching. No comparative studies were done on the average length of time spent with patients, on duty, or in teaching activities. With the increase in size and complexity of the agency, the efforts to meet State and Federal regulations, all staff are required to attend many more meetings, both educational and planning. This together with the additional paperwork, requires that much more time be invested in non-patient care activities. The quality of care offered is further examplified by the Joint Commission Hospital Accreditation of the Mary Breckinridge Hospital.

TABLE XVIII

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Number and Percentages of Visits*
According to Site and Provider During
Calendar Years 1974 and 1976

1974	PHYSICIAN		P.C. NURSE		REG. NURSE		OTHER		TOTAL
	No.	%	No.	%	No.	%	No.	%	
P.C. Med. Center	6092	46.7	5697	43.7	618	4.7	433	3.2	13036
P.C. Health Clinic	653	4.9	6246	47.6	6145	46.9	52	.4	13096
Home	111	.77	5030	35.1	7152	50.	2013	14.1	14306
TOTAL	6856	16.9	16973	41.9	13915	34.4	2498	6.1	40438

1976	PHYSICIAN		P.C. NURSE		REG. NURSE		OTHER		TOTAL
	No.	%	No.	%	No.	%	No.	%	
P.C. Med. Center	5656	32.5	9235	53.1	1518	8.7	986	5.6	17395
P.C. Health Clinic	660	6.3	7033	67.1	2485	23.7	138	1.3	10472
Home	121	1.1	2473	21.7	4984	43.7	3815	33.4	11393
TOTAL	6437	16.5	18741	47.8	8987	23.0	4939	12.6	39260

*Twenty leading diagnostic categories in each of three sites only used.

It should be noted that the Joint Commission on Hospital Accreditation visitors questioned the use of the primary care nurse in the Emergency Room. This was considered irregular, but they noted that the quality of care was good. It is therefore significant that the final report did not list this as a deficiency. The use of the family nurse-midwives in the hospital was not questioned. The hospital privileges of the family nurse as defined in the Medical Directives (1975) have since been reinstated. It should be noted that the role of the primary care nurse was gradually broadened and clarified during the Project Period.

4) Type of Patient According to Location and Diagnostic Categories: Table XIX presents the eighteen leading diagnostic categories in 1974, according to the site where the patient sought care. This illustrates the differences in site in which people seek care according to illness. Approximately 64% of the no abnormalities were seen in the P.C.H. Clinics. No abnormality refers to well child, school health, and adult care. The greater portion of the chronically ill, 65-85%, were seen through the P.C.H. Clinics. Patients with acute problems are more apt to seek care at the P.C.M. Center. This was particularly noticable in relation to trauma, where 63-73% went to the P.C.M. Center. In the care of otitis media, which is painful, half of the patients also went to the P.C.M. Center. Normal pregnancy was seen more frequently at the P.C.M. Center, because midwifery patients are encouraged to go to the hospital. Other categories fell in between. It

TABLE XIX

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Leading Diagnostic Categories of Patients Seen According to Location
January 1974 - August 1974

Order of Frequency	ICDA Code	Diagnostic Category	District Visits		Hospital Visits		TOTAL	
			No.	Percent	No.	Percent	No.	Percent
1	000.1	No Abnormality	2678	64	1500	36	4178	11.4
2	460.0-465.0	Acute URI's	2386	58	1733	42	4119	11.2
3	381.0-381.9	Otitis Media	1393	50	1373	50	2766	7.5
4	401.0-401.9	Hypertension and High Blood Pressure	2185	79	504	21	2689	7.5
5	412.9-413.0 427.0	Cardiovascular Conditions	2236	85	338	15	2574	7.2
6	470.0-480.0 486.0-491.0 489.0-491.0	Influenza, Pneumonia Bronchitis Asthmatic Chronic	1572	65	870	35	2442	6.7
7	679.0-679.1	Normal Pregnancy	617	33	1256	67	1873	5.0
8	580.0-593.9 599.9 786.0-786.9	Kidney Infections U.T.I.'s Genito-urinary symptoms	983	64	556	36	1539	4.2
9	250.0-250.9	Diabetes Mellitus	1105	78	323	22	1428	3.9
10	492.0 493.9	COPD, Emphysema Asthma	1010	74	371	26	1381	3.8
11	531.0-533.9 984.0-985.9	Ulcers, duodenal, gastric GI Symptoms	699	54	593	46	1292	3.5
12	273.9, 894.0 949.0-949.9	Lacerations, open wounds Burns	409	37	700	63	1109	3.0
13	712.9-713.0	Rheumatoid and Osteo Arthritis	838	81	206	19	1044	2.9
14	602.1 626.0-626.9 630.0, 678.0	Vaginitis, Vulvitis Menstrual Disorders Complications of Pregnancy	399	48	433	52	832	2.3
15	829.1-829.9 929.0	Fractures, Sprains, Contusions	218	27	601	73	819	2.2
16	034.0	Strep Throat	451	59	323	41	774	2.1
17	126.0-129.0	Worms & Parasites	505	75	168	25	673	1.8
18	280.0-281.9	Def. Anemias	367	66	187	34	586	1.5

	DISTRICT	HOSPITAL	TOTAL
Total Leading Diagnostic Categories	20,046	12,165	32,211
Other Diagnostic Categories	10,855	7,172	18,027
TOTAL DIAGNOSTIC CATEGORIES	30,901	19,337	50,238
Total Patient Encounters	20,362	16,477	36,839
Diagnostic Categories per Patient	1.51	1.17	1.36

is interesting to note that P.C.H. Clinics listed 1.51 diagnostic categories per patient seen compared with 1.17 in the P.C.M. Center. This no doubt is related to the factor that a higher percentage of chronically ill patients have multiple problems, and these patients are served more frequently through the P.C.H. Clinics. The majority of these patients have been previously examined by the physician and therefore have a medical diagnosis and management regimen. The homebound generally have a medical plan of care, as required by Medicaid/Medicare.

5) Diagnostic Categories According to Type of Provider:
Table XX shows the ten leading diagnostic categories according to type of provider in 1976. It should be noted that there is a further shift in leading diagnostic categories since 1974. This shift in common diagnosis has not yet created a need for realignment in the curriculum, but the decrease in health assessment and preventive care is causing faculty to look more critically at this content as it needs to be reinforced early in the curriculum.

It is interesting to note that while the site of the visit varies considerable according to the diagnostic category, the frequency with which the physician sees the patient tend to vary relatively little in relation to diagnostic categories. There is much greater variation between the diagnostic categories which are seen by the primary care nurse and the registered nurse and other. The registered nurse, the L.P.N.'s and aides provide the highest proportion of care to chronically

TABLE XX

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

The Ten Leading Diagnostic Categories According to Type of Provider
January 1, 1976 - December 31, 1976

	PHYSICIAN		P.C. NURSE		REG. NURSE		OTHER		TOTAL	
	No.	%	No.	%	No.	%	No.	%	No.	%
1. No Abnormality	707	14.2	2567	51.5	1034	20.7	678	13.6	4986	100.0
2. Otitis Media	771	19.3	2489	62.2	647	16.2	95	2.3	4002	100.0
3. Normal Pregnancy	872	26.0	2335	69.8	81	2.4	59	1.8	3347	100.0
4. Hypertension	667	20.4	1091	33.4	1126	34.5	382	11.7	3266	100.0
5. Diabetes	328	18.0	381	21.0	753	42.0	322	18.0	1784	100.0
6. Common Cold	208	13.9	839	56.0	402	26.9	48	3.2	1497	100.0
7. U.R.I.	339	23.7	868	60.7	185	12.9	39	2.7	1431	100.0
8. U.T.I.	250	20.2	549	44.5	261	21.2	173	14.1	1233	100.0
9. Family Planning	188	15.6	910	75.4	95	7.8	15	1.2	1208	100.0
10. Pharyngitis	149	15.4	627	64.7	175	18.1	18	1.8	969	100.0
TOTAL	4478	18.9	12656	53.3	4759	20.1	1829	7.7	23723	

ill patients, which is largely nursing care in the home and involves minimal primary care.

These tables indicate that the type of problem determines to a large extent the site where patients are apt to seek care, but not the skill level of the provider. This, however, is not true of all areas since the families living in the vicinity of the P.C.M. Center do not have similar access to P.C.H. Clinics. The tendency for physicians to see equal proportions of patients in the different diagnostic categories is related more to reimbursement mechanisms, than to the need for medical care. Patients with Medicaid and Medicare privileges must be seen by the physician in order for the FNS to claim reimbursement. Otherwise the patient is expected to pay his own fees, and few can afford this. Physicians find this extremely frustrating as do the nurses since this is not the best utilization of health manpower skills, and it reduces the availability of the skill of the physician where he is most needed. This takes physicians away from the work he has really been trained to do.

Table XX also shows that the physicians see only 18.9% of the patients. Half of these have been previously seen by the P.C.N. or the R.N. The P.C.N.'s (including graduates and trainees) see 53.3% of all patients. Some of these are referrals by the R.N. or others, e.g. the L.P.N. The P.C.N. may, under these circumstances, consult in person or via phone with the physician.

6) Assessment of Patients According to Site of Visit:

Table XXI indicates differences between the assessments of

TABLE XXI

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Incidents of Assessment of Condition
According to Site of Visit
August 1976

	PRIMARY HEALTH CARE CLINIC		PRIMARY MEDICAL CARE CENTER		TOTAL NUMBER OF INCIDENTS	
	No.	Percentage	No.	Percentage	No.	Percentage
History	1673	46	1953	54	3636	100
Vital Signs	1541	45	1911	55	3452	100
Complete History & Physical	171	64	96	36	267	100
Developmental	43	81	10	19	53	100
Psycho-Social	92	81	22	19	114	100
Pre & Post Op.	10	52	9	48	19	100
Review of Systems	2983	44	3726	56	6709	100
MCH	281	39	436	61	717	100
TOTAL INCIDENTS	8244	46	9525	54	17,769	100
LAB TESTS	1797	48	1926	52	3723	100
PATIENTS VISITS	2666	48	2880	52	5546	100

the condition of the patient according to site. The nurses in district clinics are more apt to do complete physicals, developmental tests in children, and psycho-social assessments, while in the hospital clinic they do significantly more maternal and child health, and a higher proportion of the review of systems, i.e. physical examinations of difficult physiological systems of the body. The overall proportion of assessments are very similar as are the number of laboratory tests in relation to the number of patients seen. The P.H.C. Clinics have minimal laboratory equipment but they have the privilege and mechanisms for sending specimens to the P.C.M. Center. They do not, however, receive the results as quickly. They may request results by telephone when urgent. The similarity in the quantity of physical and laboratory tests between the two sites is somewhat surprising, as is the great variation in the developmental and psycho-social assessment, which indicates that 81% of these types of assessments occur in the district clinics for 48% of the patients seen.

Table XXII illustrates the major differences that occur in the assessment of Health Care Practices in the P.H.C. Clinics, in comparison to the P.C.M. Center, with 70% occurring through the district clinics. The greatest differences lie in the areas of personal care, environmental conditions, management of stress and grief, and interpersonal relationships. This is no doubt related to the less formal nature of visits in the district clinics, the nurses familiarity

TABLE XXII

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Incidents of Assessments of Health Practices
According to Site of Visit
August 1976

	PRIMARY HEALTH CARE CLINICS		PRIMARY MEDICAL CARE CENTER		TOTAL INCIDENTS	
	No.	Percentage	No.	Percentage	No.	Percentage
Nutrition	838	52	765	49	1603	100
Elimination	830	67	408	33	1238	100
Sleep	562	75	185	25	747	100
Physical Activity	789	76	248	24	1037	100
Personal Care	387	87	57	13	444	100
Family Planning	46	48	50	52	96	100
Environmental	189	92	16	8	205	100
Drug & Alcohol Use	34	61	22	39	56	100
Stress & Grief	80	87	12	13	92	100
Interpersonal Relationships	104	96	4	4	108	100
Use of Medication	838	52	765	48	1603	100
TOTAL INCIDENTS	4580	70	1995	30	6575	100
PATIENT VISITS	2666	48	2880	52	5546	100

with the home and the community environs of the family, and the continuity of care she is able to provide. This difference was also noted by Golladay, Smith et al (1974) from the University of Wisconsin in their study of the different levels of health practitioners. This difference is particularly significant when one realizes that 71% of all patients in the P.C.M. Center are seen by the primary care nurse. So this difference cannot be attributed entirely to the type of provider since the primary care nurse sees roughly 70% of all patients in both sites. This implies that the type of assessments performed vary much more in relation to the nature of the site where the encounter occurs rather than in relation to the provider who gives the care.

Table XXIII indicates that there is also a major difference in the type of assessment and the amount of teaching and counseling done by the primary care nurse in comparison to other providers.

Table XXIV indicates that while more Maternal Child Health Assessment Services are provided through the P.C.M. Center, which conducts midwifery clinics four days a week, more well child care is provided in the P.C.H. Clinics, even though the P.C.M. Center conducts a pediatric clinic with pediatric nurse practitioners 5 days a week. Also while special Family Planning Clinics are conducted at the P.C.M. Center, almost as much assessment of Family Planning is done in the P.C.H. Clinics.

TABLE XXIV

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Incidents of Assessment Preventive Services in Maternal Child Health Care
August 1976

	PRIMARY HEALTH CARE CLINICS		PRIMARY MEDICAL CARE CENTER		TOTAL INCIDENTS	
	No.	Percentage	No.	Percentage	No.	Percentage
Prenatal	76	27	202	73	278	100
Postpartum	29	35	54	65	83	100
Neonatal	21	32	45	68	66	100
Family Planning	37	44	47	56	84	100
Well Child	119	57	88	43	207	100
TOTAL INCIDENTS	282	39	436	61	718	100

7) Teaching and Counseling Services According to Site:

Table XXV presents some of the most significant data of this study in that it demonstrates the major difference between the services provided in the P.C.M. Center and the P.C.H. Clinics. The P.C.H. Clinic provides 63% of all incidents of health teaching and counseling. The greatest difference lies in the health practice teaching and counseling in which the P.C.H. Clinics provide 74% of the incidents that occur.

As one would expect in health status counseling, the greatest difference lies in the preventive and maintenance counseling, with the P.C.M. Center doing considerably more curative counseling in relation to the physical condition of the patient. The areas in which the greatest differences occur are in relation to developmental and psycho-social counseling. The same differences are noted in health practice teaching and counseling. The P.C.H. Clinics do 89% of developmental and 88% of the psycho-social counseling; 95% of the environmental counseling; 91% of stress and grief counseling; and 92% of interpersonal relationship counseling. Other areas of health practice counseling which relates to life style are also conducted more frequently in the P.C.H. Clinics. This table is particularly worthy of study since it indicates the type of health activities to which the primary care nurses will devote time when given the autonomy.

8) Therapeutic Procedures and Care According to Site:

Table XXVI indicates frequency of therapeutic procedures, referring to technical procedures, according to site. This

FRONTIER NURSING SERVICE
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Teaching and Counseling Services
Provided According to Site of Visit
August 1976

AREA	PRIMARY HEALTH CARE CLINICS								PRIMARY CARE MEDICAL CENTER								TOTAL NO.
	Prevention		Maintenance		Curative		Sub-Total		Prevention		Maintenance		Curative		Sub-Total		
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	
Condition:																	
History	400	38	290	27	366	35	1056	43	290	21	234	17	854	62	1378	57	2434
Complete History & Physical	75	71	20	19	11	10	106	55	38	47	28	32	21	24	87	45	193
Vital Signs	373	29	487	38	419	33	1279	51	357	29	192	16	678	55	1227	49	2506
Developmental	21	43	18	37	10	20	49	89	6	100	--	--	--	--	6	11	55
Psycho-Social	32	25	52	41	44	34	128	88	4	22	8	45	6	33	18	12	146
Review of Systems	99	17	33	06	439	77	571	48	1	--	87	14	538	86	626	52	1197
SUB-TOTAL	1000	31	900	28	1289	41	3189	49	696	21	549	16	2097	63	3342	51	6531
Health Practices:																	
Nutrition	405	34	504	42	287	24	1196	68	205	37	59	11	286	52	550	32	1746
Elimination	237	28	413	48	211	24	861	82	94	49	14	7	84	44	192	18	1053
Sleep	236	30	353	45	202	25	791	76	153	62	11	5	81	33	245	24	1036
Physical Activity	312	27	497	42	361	31	1170	77	129	37	38	11	182	52	349	23	1519
Personal Care	172	29	258	43	167	28	597	87	34	37	12	13	45	50	91	13	688
Family Planning	34	57	21	35	5	8	60	48	57	89	4	6	3	5	64	52	124
Environmental	179	52	94	28	69	20	342	95	5	29	1	6	11	64	17	5	359
Drug & Alcohol Use	13	28	14	30	19	41	46	62	13	46	2	8	13	46	28	38	74
Immunization	170	82	35	17	3	1	208	84	25	61	11	27	5	12	41	16	249
Stress & Grief Management	23	16	29	21	88	63	140	91	3	21	1	7	10	71	14	9	154
Interpersonal Relations	15	10	33	22	103	68	151	92	6	46	1	8	6	46	13	8	164
Use of Medications	252	21	403	37	541	45	1196	61	147	19	98	13	526	68	771	39	1967
SUB-TOTAL	2048	30	2654	40	2056	30	6758	74	871	37	252	10	1252	53	2375	26	9133
Maternal/Child Health:																	
Prenatal	49	86	6	11	2	3	57	24	177	99	--	--	2	1	179	76	236
Postpartum	13	65	7	35	--	--	20	33	40	100	--	--	--	--	40	67	60
Family Planning	9	75	3	25	--	--	12	27	32	100	--	--	--	--	32	73	44
Neonatal	11	79	2	14	1	7	14	26	38	97	--	--	1	3	39	74	53
Well Child	29	100	--	--	--	--	29	89	4	100	--	--	--	--	4	21	33
SUB-TOTAL	111	84	18	14	3	2	132	31	291	99	--	--	3	1	294	69	426
GRAND TOTAL	3159	31	3572	36	3343	33	10074	63	1858	31	801	13	3353	56	6012	37	16086

TABLE XXVI

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Therapeutic Procedures Performed
According to Site of Visit
August 1976

	PRIMARY HEALTH CARE CLINICS		PRIMARY MEDICAL CARE CENTER		TOTAL INCIDENTS OF CARE	
	No.	Percentage	No.	Percentage	No.	Percentage
Sutures	7	12.5	49	87.5	56	100
Wound Dressing	39	35.0	71	65.0	110	100
Other	72	26.0	208	74.0	280	100
Drug Pres. Refilled	786	52.0	711	48.0	1479	100
Drug Administered	249	70.0	108	30.0	357	100
Over-the-Counter Drug Rec.	62	34.0	121	66.0	183	100
TOTAL INCIDENTS	1197	49.0	1268	51.0	2465	100
PATIENT VISITS	2666	48.0	2880	52.0	5546	100

has the P.C.M. Center performing many more therapeutic procedures than are performed at the P.C.H. Clinic as one would expect. Other procedures include minor surgery, I.V.P.'s, proctoscopies, sphygmoidoscopies, fracture and cast care which require the skill of the physician.. It should be noted that suturing, removal of sutures and wound dressings are performed primarily by the nurse in the P.C.M. Center unless major trauma is involved. Drugs are refilled and administered more frequently in the P.C.H. Clinics.

Therapeutic care, which refers to the personal type of health services, is more frequently performed through the P.C.H. Clinics as noted in Table XXVII. These are largely nursing procedures and the greater proportion are performed in the home. A great deal of effort is directed toward teaching the family and the individual self care where this is appropriate. It is felt that health teaching is done most effectively in the home where the nurse serves as the role model in familiar environs, and where the nurse must operate under the same conditions and utilize the same resources which the family has available to them. She needs to ask fewer questions which are often embarassing to the patient. The circumstances enable the nurse to be much more sensitive to both the limitations and strengths within the home and the family.

Table XXVIII indicates the number of patients seen according to skill level of provider and reason for visit. By totalling all acute/trauma care provided, including follow-up, it is

TABLE XXVII

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Incidents of Therapeutic Care
According to Site of Visit
August 1976

TYPE OF CARE	PRIMARY HEALTH CARE CLINIC		PRIMARY MEDICAL CARE CENTER		TOTAL INCIDENTS	
	No.	Percentage	No.	Percentage	No.	Percentage
Respiratory	64	98	1	2	65	100
Physical Therapy	166	96	7	4	173	100
Personal Care	176	99	2	1	178	100
Skin Care	190	92	16	8	206	100
Elimination	44	96	2	4	46	100
Other	66	87	10	13	76	100
TOTAL INCIDENTS	677	95	38	5	715	100
PATIENTS SEEN	2666	48	2880	52	5546	100

TABLE XXVIII

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Average Number and Percentages of Encounters per Month According to Skill Level of Provider and Reason for Visit by Site - 1976

				ALONE			COMBINATION*		
REASON FOR VISIT			TOTAL	M.D.	P.C.N.	P.C.N. TRAINEE	MD + PCN	PCN + TR.	MD + TR.
ACUTE - TRAUMA									
	P.C.M. Center:	Average	328	46	36	150	23	60	13
		Percent	100.	14 %	11 %	45.7%	7 %	18.2%	4 %
	P.C.H. Clinic:	Average	349.3	24	287	14	24	.3	0
		Percent	100.	6.8 %	82.1 %	4 %	6.9 %		
ACUTE - FOLLOW-UP									
	P.C.M. Center:	Average	78.3	16.6	11.8	27.5	6.6	10.3	5.5
		Percent	100.	21.2 %	15 %	35.1%	8.4 %	13.1%	7.0 %
	P.C.H. Clinic:	Average	165.8	6.3	134	8.5	16.5	.3	.2
		Percent	100.	3.8 %	80.7 %	5.1%	10. %	.2%	.1 %
CHRONIC ROUTINE									
	P.C.M. Center:	Average	78.3	24	7	28	3	16	.3
		Percent	100.	41.8 %	8.9 %	3.5%	.1 %	20.5%	.8 %
	P.C.H. Clinic:	Average	168	21	112	28	7	0	0
		Percent	100.	12.5 %	66.6 %	16.6%	4.1 %	0	0
CHRONIC FLARE-UP									
	P.C.M. Center:	Average	20.5	4	.8	9	.7	5.3	.7
		Percent	100.	19.4 %	4 %	45 %	3 %	25 %	3.5 %
	P.C.H. Clinic:	Average	40	9	20	9	2	0	0
		Percent	100.	22.5 %	50 %	22.5%	.05%	0	0
ASSESSMENT/PREVENTION									
	P.C.M. Center:	Average	352	41	97	104	8	39	63
		Percent	100.	12 %	27 %	30 %	2.2 %	11 %	17.8 %
	P.C.H. Clinic:	Average	428	14	345	52	13	2	2
		Percent	100.	3.2 %	81 %	12.1%	3.0 %	.5%	.5 %
TOTAL									
	P.C.M. Center:	Average	857.1	131.6	153.6	318.5	41.3	130.6	82.5
		Percent	100.	15.3 %	17.9 %	37.2%	4.8 %	15.2%	9.6 %
	P.C.H. Clinic:	Average	1151.1	74.3	898	111.5	62.5	2.6	2.2
		Percent	100.	6.5 %	78.0 %	9.8%	5.4 %	.2%	.2 %
GRAND TOTAL		Average	2009.2	205.9	1051.6	430.0	103.8	133.2	84.7
		Percent		10.2 %	52.3 %	21.4%	5.1 %	6.6%	4.2 %

*Does not include all skill level combinations reported, e.g. MD + Other, PCN + Other, Trainee + Other, MD + PCN + Trainee, and Other including R.N., L.P.N., Aides, Lab and X-ray Technicians, Pharmacist, Social Workers, Physical Therapist and Dentist found that 45.8% of the visits in this area are provided by the primary care physician and primary care nurse; chronic illness takes up only 15.2% of the visits; and 39% of the preventive care visits. Physicians provide 10.2% of service by themselves and in 9.3% of the encounters they are called in by the nurse for consultation. The primary care nurse sees 52.3% of the patients by herself. She supervises the P.C.N. Trainee in an additional 6.6% of the patients and seeks consultation from the physician in 5.1% of the patients seen. The P.C.N. Trainee sees 21.4% of the patients by herself and 10.8 are seen in conjunction with the physician and the primary care nurse. In other words the trainees are seeing 2 out of 3 of the patients they see, without direct supervision. This does not include telephone consultations, or consultations in which the physician or the primary care nurse do not have direct contact with the patient. Average total number of visits per month by the FNS in 1976 was 4,688, indicating that over half of the visits were made by others than the primary care physician and primary care nurse.

9) Analysis of the Productivity and Accessibilty of Services and Actions Taken to Improve Care and Broaden Services:

If the term productivity is used solely to signify an increase in number of visits, the FNS has had no increase in productivity. In fact we would have to say there has been an actual decline in productivity. In the past 30 years the number of visits have fluctuated between 47,475 - 61,288 visits per annum. In 1976 they totalled 56,259. This includes new services such as dentistry, increased social work and physical therapy input. The FNS believes this decrease in visits is appropriate, since Family Planning has helped decrease the birth rate by 50%. Systematic immunizations has almost irradicated the common communicable diseases. Control of intestinal parasites, low STD (the new term for VD) rates, and reduction of TB rates (e.g. no new cases in the county in two years), have lessened the need for management of these conditions. Better nutrition and environmental conditions have led to a reduction in the related diseases. Continuing emphasis on health education has increased the overall sophistication of the community in relation to self care. Thus while the FNS has broadened the population base it serves, it has not had any increase in the utilization of its outpatient services. This modifies the belief that the demand for outpatient services will increase ad infinitum if made readily available.

Because of increased availability of medical services fewer patients have been transferred or referred to the Medical Center, which has resulted in increased utilization of the community hospital. With improved transportation more patients from surrounding areas are also seeking services at the FNS, though this number tends to be small, as noted in Table XXIX. According to this table less than 5% of the patients came from outlying areas. People in the rural Appalachia tend to seek care close to home. Similar findings are reported in the World Bank Health Sector Policy Paper (1975).

TABLE XXIX

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Average Number of Visits at FNS in District
and Hospital Outpatient Clinic by Residence of Patient
May - October 1976

RESIDENCE	LOCATION OF VISIT			
	Primary Care Health Clinic		Primary Care Medical Center	
In District*	1716	96%	2632	99%
Out of District**	45.5	2.5%	3	.1%
Out of State	24.5	1.5%	19	.8%
TOTAL	1786	100%	2654	100%

*District refers to geographic areas served by the Primary Care Health Clinic.

**Out of District refers to other areas within Kentucky.

While the utilization of outpatient services appear to be declining, the FNS would like to believe that the quality of services and care provided has improved. Diagnostic and therapeutic modalities have been broadened, and evaluative and utilization studies refined. Further studies, however, are needed to determine the extent to which the services offered have improved the health status of the people served. Studies are being proposed to show the number of individuals seeking care for given conditions, the frequency of their hospitalization and related complications, using the tracer methods to determine impact .

The FNS during the past five years has made every effort to improve services by complying with regional, state, national and federal regulations that have been established to assure the adequacy of care and training provided. The FNS has received:

1) American College of Nurse-Midwives (ACNM) approval for its Nurse-Midwifery Program;
2) State certification from the Medicare/Medicaid Program for the FNS Home Health Agency;
3) Accreditation from the Joint Commission on Hospital Accreditation, for the Mary Breckinridge Hospital;
4) State Licensure for FNS Primary Care Agency; and
5) American Nurse's Association (ANA) accreditation visit for the Family Nurse Training Program.

Much effort has gone into the promotion of State and National legal recognition of primary care nursing and third party reimbursement for nursing for preventive and for health maintenance care as noted in House Ways and Means Subcommittee Testimony (1976), Senate Rural Development Subcommittee Testimony (1977). Until reimbursement is available, it is not economically feasible to increase productivity by extending the services or increase accessibility to the total population served. As noted earlier, in order for the agency to collect for third party reimbursement, physicians must see the patient. This is an injustice to the patient, the agency and the providers. It diminishes productivity, appropriate utilization of the limited medical services available, and it increases cost to both the agency and the patient.

A proposal for a random record audit system (Appendix J), in which services will be reviewed according to established Medical Directives, not the credentials of the provider has been developed. The aim is to promote productivity on the basis of quality of service provided and in accordance to the competency with which it is carried out. If a nurse has been prepared to manage upper respiratory infections and does an adequate job, why have an internist manage such conditions when his skills can be utilized more effectively in conducting diagnostic and therapeutic procedures in the care of cardiac conditions. Also why should he be held accountable for implementing care that can be performed as effectively by the nurse.

It should be noted that each time a new physician or nurse joins the staff, each has to experiment with his new role to establish a comfortable niche for himself. For example, the internist has to determine at what point he is comfortable in referring a patient back to the nurse and the nurse must establish a comfortable consultant relationship with the physician, to allow for maximum utilization of each others skills. This is a maneuver that must be anticipated in any new professional relationship. The more familiar physicians are with the primary care nursing role, the less problematic their introduction into the system.

The FNS has been established from the beginning for the purpose of making health care reasonably accessible to the people. Nursing clinics were established within a five mile radius since this was considered the maximum distance that people could or should travel for maternal and child health care. This distance has stood the test of time well. Studies indicate that few people do indeed travel further than this to seek health care at the clinic, and the 65 and over age group are the least likely to go beyond their home in search of health care. The greater the discomfort the more apt the family is to travel the 20-30 miles to the P.C.M. Center. Table XVI, p. 88, showed the age distribution of visits according to site of visit, home, P.C.H. Clinic and the P.C.M. Center visit. This shows that the aged are the least apt to seek care outside the home, with the greatest proportion (62.3%) of the visits for this age group occurring in the home.

The FNS has experimented with weekly medical clinics at the district clinics with only questionable success. Many are poorly attended and further evaluation is needed to determine whether such clinics are economically feasible. Indications are that the more acute the illness (the pain or discomfort) the further people are willing to travel to seek care, which makes greater centralization of medical care more practical and economically feasible. This is accentuated by the need for more complex equipment, e.g. lab, x-ray, EKG, etc., and other hospital facilities as well as the greater availability of medical consultation in the different specialties.

10) A Description of the System as it Maximizes Accessibility to Care:

The FNS system as it has been established provides the following accessibility to care:

a) Primary Care Health Services - One nurse can adequately serve approximately 150 families or 450-500 individuals in a P.C.H. Clinic. Density of the area determines whether more than one, two, or three nurses should be assigned to a P C.H. Clinic and the number of R.N.'s, L.P.N.'s, or aides and clerical assistance needed. This distribution of nursing personnel should permit an average of 4 visits per individual per annum and 8 visits per day per nurse. This is considered the maximum that the average nurse can manage in view of the amount of paperwork, administrative duties and travel involved in providing both home and clinic services. It is estimated that nurses tend to spend an average of twice the amount of time with patients compared with physicians. No data is available to confirm this. The amount of time spent with a patient varies vastly according to provider practices and patient needs.

Types of services provided also vary. Patients say that nurses allow them more time to ask questions. Studies by both Marion Pearsall (Appendix H) and the University of Wisconsin (1974) support the difference in the content of the nursing visits in the district. This is confirmed by our own studies. Furthermore patients will also testify to this difference.

b) Primary Care Medical Services - Seven physicians employed at the centrally located hospital clinic or the P.C.M. Center, should be able to manage approximately 18,000 patient visits per annum, an average of 10 patient visits per day per physician for a population of 16,000-20,000 with an average of one visit a year per individual.

In accordance with the above system nurses and physicians together see each individual an average of 5 times a year. The actual average number of visits per individual at the FNS is estimated at 5.2 visits per annum per individual. This figure has remained relatively constant since 1949, ranging from 4.8 - 5.8 visits per individual per annum during this time period. This figure is slightly higher than the national average of 4.7 according to the AMA Reference Data on Socio-Economic Issues of Health, 1971, Revised Edition. It should, however, be noted that FNS data includes Home Health Services for the homebound, which should increase total average number of visits.

c) Primary Care Hospital Services - The FNS operated a 25 bed hospital at the time this study was initiated. This was increased to 40 beds in 1975 when the new hospital and health center was opened. Average number of hospital days per individual service was .65 per year from 1969 - 1974. This varied very little between 1949 and 1974. There was an increase to .74 between 1968 - 1969 when there was a marked decrease in district visits. This change occurred when the FNS physicians reduced referrals back to the district. Hospitalization during these two years peaked at .98 hospital days per individual in 1969 which is more comparable with the national average of 1.2 days. This suggests an inverse relationship between district visits and hospitalization. It should be noted that average outpatient visits during this same two year period increased to 6.3 per annum.

Further studies are needed to determine the appropriate balance between primary health care, primary medical care, and hospitalization to assure maximum utilization and effectiveness of each. The tracer study by Gordon and Isaacs (1976), on the diabetic, would indicate that a similar reduction in hospitalization could be achieved through the decentralization of health services in the care of other chronic diseases. Further studies are needed of the various disease categories to demonstrate how accessibility of care through decentralized services can be maximized to assure appropriate care, and efficient utilization of manpower, in relation to cost benefits.

d) Specialty Care or Tertiary Care - Specialty care services available at the FNS are very limited. Therefore it is most important that outside linkages be established. With the increase of services available at the FNS it is interesting to note that both the actual number and the percentage of hospital patient specialty care outside the FNS has continued to increase. In 1974 43 or 3.0% of all patients admitted were transferred for specialty care. In 1976 this had increased to 63 or 3.5% of all patient admissions. On the other hand the number of outpatients referred for specialty care has decreased from approximately 2-3 per day to 2-3 per week. This reduction in outpatient referrals is attributed largely to the presence of both an internist and surgeon on the staff. The increase in hospital referrals on the other hand is attributed to the increased ability of the physician to perform more extensive diagnostic work-ups, due to greater availability of diagnostic facilities and equipment. Therefore they are more likely to admit a patient prior to referral.

It should be noted that the nearest Medical Center is 2½ hours travel time or 125 miles from the FNS. In addition there are three regional hospitals within 35 miles distance. Two of these have certain specialists, such as a neurologist, an orthopedist, an ophthalmologist, and ENT specialists, which could not be efficiently accommodated by a small agency like the FNS. Two of the above specialists conduct monthly clinics at the FNS. Transportation however remains a major problem. The County is still awaiting its first approved ambulance service. Availability of consultation and referral cources for specialty care, as noted above, are of prime importance in conducting a rural primary care agency to assure accessibility to and appropriate utilization of specialty services.

b. Quality of Service Studies - The FNS has established Medical Directives (frequently referred to as Algorithms or Medical Protocols) which provide clearly defined guidelines for standards of care, e.g. frequency of follow-up visits and the management of the well child, the childbearing mother, family planning, the common health problems, and emergency care. Appropriate standards for management of the well adults have been less clearly defined with one exception, the annual physicals for the adults employed by the FNS. The above Directives are essential for establishing guidelines against which to measure quality of service provided. This does not reflect quality of care or outcome.

Two studies were conducted by outside agencies to reflect quality of service provided.

1) Study by Ira Moscovice on Quality and Utilization of Services: Ira Moscovice, a doctoral student from Yale University, conducted his dissertation study at the FNS using their encounter data and Medical Directives to develop a method for analyzing utilization of ambulatory care services,

according to disease category, age and sex of patient, and by provider. This provided a beginning step in the analysis of the quality of service provided according to the different skill levels of the practitioners. In his study of otitis media and tonsillitis/pharyngitis, he found that the use of medications was affected primarily by the setting, while use of laboratory tests was determined by comordidities (the presence of other symptoms) and setting. In district (P.C.H. Clinics) where transportation is a more immediate problem and the provider generally more acutely aware of the nature of the family and home situation, the provider is more apt to rely upon antibiotics in the management of upper respiratory infections and also more apt to prescribe palliative measures. Laboratory tests on the other hand are used less frequently in the P.C.H. Clinic where they are not as readily available. The 1976 data indicates an increased use of laboratory tests in P.C.H. Clinics comparable with those used at the P.C.M. Center.

The management of upper respiratory infections such as otitis media or tonsillitis/pharnygitis which do not require complex technology or skill was not significantly affected by the skill level of the provider. Skill levels involved in this study were the registered nurse, the primary care nurse, and the physician. A wide variation of factors involved in determining treatment and frequency of follow-up, such as site and nature of the condition were noted. The effect these had on the patterns of care and management were more significant than was the skill level of the provider. In the hospital clinic, with more readily available laboratory facilities and medical consultation, providers were more reluctant to initiate treatment until the diagnosis was confirmed. This indicates that the site had a greater influence on health care management than did the skill level of the practitioner.

Greater differences were noted in the management of urinary tract infections which required greater technological skills, e.g. microscopic urinalysis and a greater discernment in clinical judgment. Registered nurses in district were more apt to treat symptomatically without laboratory tests as well as use both palliative medications and antibotics than were the primary care nurses, who tended to use more laboratory tests and less medications. These patterns of care resulted in higher drug charges and lower laboratory charges in the district with greater total charges in the hospital for both conditions. Outcome and cost benefit studies are therefore needed to determine the practicality of increased dependency upon laboratory tests as a basis for treatment.

Patterns of investigation used for establishing treatment modality were medically meaningful and statistically relevant. Costs of studies of this nature are costly and time consuming. On the other hand they are essential for long term scientific evaluation of services. The conclusions drawn by Ira Moscovice in his study were:

"That a decentralized primary care system, such

> as the one developed by FNS, certainly increases the the accessibility of health care services to the residents of a rural area. The availability of equipment and facilities significantly influence the patterns of care in the treatment of most primary care problems, whereas advanced training of providers significantly influences patterns of care in the treatment of the more complex primary care problems, such as urinary tract infections. The savings in costs in the use of the lesser trained personnel in such a system are reflected primarily in reduced salaries, but also exists in slightly reduced treatment costs."

2) The Golladay and Smith study (1974) which was designed to identify the functions of the primary care nurse in relation to other health care providers, noted major differences both in the quantitative and qualitative content of the primary care nursing visits. These were most notable in relation to home visits. This was particularly evident in"1) past and present medical history taking; 2) detection and early treatment of problems; and 3) sympathetic listening and life counseling." The average visit was noted to contain twice as many task combinations with greater frequencies of counseling, teaching and consultations. The home visits were most difficult to code because of the non-directive approach used in obtaining history and providing counseling, but they were considered most effective by the observers.

> "When observing the Frontier Nursing Service Program one is continually aware of the qualitative concern of the nurses for the people in their districts. This concern extends beyond the primary care provided in the more traditional medical care setting.."

Data from the study also indicated interesting relationships in nurses' functions during the clinic versus home visit. As noted:

> "...Large portions of encounters consisted of

> conversation which superficially seem to be strictly social conversation, but in reality was a method of gathering historical data about the patient, or people in the community."

c. Quality and Outcome of Care Studies - Quality and outcome of care is the crux of service effectiveness. Studies have been completed in some areas which indicate a relatively high quality of care.

Studies by Browne and Isaacs (1976) of maternal child health care, utilizing maternal and perinatal mortality rates indicate a consistently low mortality rate in comparison with state rates as indicated in Table XXX. Leslie County perinatal mortality rates for 1973-1975 were 22.3 per 1,000 live births compared with 24.8 for the State for a total of 758 live births (Vital Statistics, Kentucky 1974). Table XXIX indicates that both stillbirth rates and neonatal mortality rates tend to be consistently below State rates. The care of the mother and child, as long as the condition of the mother falls within the normal range during the childbearing process, is managed by the nurse-midwife. (The majority of the nurse-midwives have family nurse training.) This denotes an excellent quality of care and outcome. Infant mortality rates are currently not as favorable. For the same period 1973-1975 Leslie County had 26.4 infant deaths per 1,000 live birth compared to 14.5 in the State. Since the Infant Mortality Rates in Leslie County in 1964-1967 was 17.7 per 1,000 live births for 1409 live births in Leslie County compared with 25.2 for the State, further studies are needed

20 Year Summary of Midwifery Services Compared with State Ratios

May 1954 - April 1974

	Number of Births						Maternal Deaths		Neonatal Deaths			Deliveries Attended by Physician					
	Live Births			Still Births											Home Deliveries		
		Rate*			Rate**			Rate***		Rate**			Percentage			Percentage	
Years	No. FNS	County⁑	State⁑	No. FNS	FNS	State⁑	No. FNS	State⁑	No. FNS	FNS	State⁑	No. FNS	FNS	State⁑	No. FNS	FNS	State⁑
1954-59	2405	31.4	25.1	32	13.3	15.1	0	4.0	42	17.4	20.0	53	2.2	NA	996	41.4	NA
1959-64	1987	38.9	22.7	24	12.0	14.4	0	4.4	40	20.1	19.1	32	1.1	99.6	559	28.1	4.7
1964-69	1613	32.4	20.7	16	9.9	13.5	0	2.1	20	12.3	16.9	71	4.9	98.4	134	8.3	2.1
1969-74	1259	21.3	18.7	17	13.5	12.6	0	2.3	16	12.7	13.9	99	7.8	99.1	28	2.2	0.9
Total	7264	37.7	22.3	89	12.2	14.1	0	2.8	118	14.8	17.8	255	3.5	97.3	1717	23.6	7.7

* Rates per 1,000 population
** Rates per 1,000 live births
*** Rates per 10,000 live births

⁑ Mid-point year used for County and State Rates and Percentages
During the 1969-74 period increased still births and neonatal death rates **were** accompanied by a rubella and flu epidemic in the area served.

to determine why the Infant Mortality Rate has risen, and if possible to determine whether the home visits for this age group does indeed have a significant impact on infant mortality. This is important because a major change in the health care delivery system occurred in this area.

It should be noted that the FNS since its inception has had a significantly lowered maternal mortality. Among the women served by the FNS there has not been a maternal death since 1952 in over 8,000 deliveries. In 1973-1975 the Maternal Mortality Rate in Kentucky was 1.9 per 10,000 live births. The National rate was 1.4 per 10,000 live births.

A study conducted by Thomas Nuzum, M.D., et al, indicated there was no evidence of malnutrition and in the growth and development status of children under two years delivered by the nurse-midwife. Children in this area despite their low poverty level compared favorably to national norms as determined by the Harvard Growth and Development Charts. Furthermore these children did not have a greater incidence of health problems than the children of the middle income group in Boston. Cursory studies of children in surrounding areas indicate a much higher incidence in deficiency conditions such as anemia in the pre-school age child. Preliminary observations from record review and statistics suggest that such care has a significant impact on the health of both mother and child. Further studies are needed to determine the impact of preventive care during the childbearing process on the health of both mother and child in later years, A study on the outcome of health care of the adult diabetic patient demonstrates that the care provided by the FNS has a significant influence on his health. Preventive care, however, does not appear to influence the incidence of the diabetic condition. The prevalence rate of 2.5 for adult onset of diabetes per 1,000 population is similar to national rates. Decentralized, family-based maintenance care provided after the occurrence of the disease substantially postpones and reduces hospitalization as well as reduces the incidence of related complications as identified in the study by Gordon and Isaacs (1977). A follow-up of this study indicates that there has been no substantial increased incidence of hospitalization in the two subsequent years.

Whether the improved health status of the diabetic patient is related to education and counseling, earlier medical intervention when deviations occur, or the psychological impact of family centered care was not singled out as a factor to be determined in this study. The FNS would like to think that each plays a role. For example, that good health teaching and counseling assures better self care and/or family care, and that early medical intervention reduces the complications which permit the diabetic to live a more constructive and self fulfilling life with the family; and that it is the psychological impact of the latter together with the first two factors that makes the difference. In that case the influence is felt far beyond the well-being of the diabetic patient alone.

The above are less tangible measures of outcome that cannot be measured by standard criteria, such as rate of hospitalization and other technological measures as indicated by the following anecdote. The author recently met an aged couple at the hospital clinic who very delightfully described their experience in the management of diabetes. The seventy-two year old wife proudly stated that the nurses in the district had taught her to be her husband's 'best nurse', and that she had taken excellent care of his diabetes for twenty-five years. The merry twinkle in the eyes of the seventy-eight year old husband implied that they still lived a happy life despite the affliction. Neither complained of the inconvenience created by the disease and both were appreciative of their continued ability to enjoy life, and of the availability of the nurse who could help them in time of need. It is this type of outcome that is the goal of the service.

The availability of computerized hospital data (PAS MAP) together with computerized Encounter Form data utilizing the same identification numbers makes studies of this nature relatively easy to conduct. Data from control groups is needed from other areas with different patterns of care to confirm the effectiveness of the system of care established at the FNS.

The incidence of hospitalization and related complications of diabetic patients were considered one of the more reliable criteria for determining health status, though not completely valid, since home health care services may be one of the factors that lessens the need for hospitalization. It should be noted that both admission rates and average length of hospital stays were reduced. Furthermore, all diabetic deaths in 1974 in Leslie County occurred past the age of 65. Only 2/3 of State diabetic deaths occurred after the age of 65 (Vital Statistics Kentucky 1974).

The degree to which other chronic illnesses will lend themselves to this type of study can only be determined by conducting similar studies of other chronic disease categories. The FNS is working with further studies of this nature, specifically related to chronic respiratory conditions. The aim is to identify those service elements that provide effective modes of intervention.

To further illustrate potential areas for study, it should be noted that this county has a limited incidence of communicable disease in comparison with surrounding counties through intensive immunization program by both the FNS and the County Department of Health. There are no known cases of cerebral palsy in the county, and it had no new cases of tuberculosis in the past two years. Deaths due to breast and cervical cancer are likewise below the State and National averages. In 1974 and 1975 there were no reported cases of cervical cancer in Leslie County. All of the above conditions are believed to be responsive to preventive measures. The impact of health maintenance care in the management of chronic disease and disability is less clearly established, however, the diabetic study indicates that it does reduce the incidence of disease related complications.

Curative care according to Breslow (1974), Lalonde (1975), and Rosen (1976), has had little impact in the prolongation of life after sixty-five, the time at which most chronic illnesses occur. For this reason, studies are urgently needed to assess the impact of family-centered maintenance care, in postponing disability and promoting functional ability of the chronically ill. This is particularly pertinent with the anticipated increase of the 65 year old and over population group.

Nursing home care of this age group has always been a relatively poor second best approach in the care of the chronically ill. Should maintenance care help postpone disability and improve functional ability, the proposed system for delivery of care would be a blessing to society, particularly for the aged and their families.

d. Health Care Costs in a Decentralized, Family-Centered Community Based Service Versus Centralized Medical Patterns of Care:

The FNS aim from the beginning has been to provide health care at reasonable costs that the people can afford to maintain. The entire system, both service and education, was developed with this intent. For this reason cost factors are presented from a historical perspective. They are divided into the following three specific time periods:

1) The first forty years (1925-1964) during which the agency was relatively autonomous;
2) The next decade (1965-1974), which covered the period in which Medicaid/Medicare and other third party payors began to plan a major role in establishing health care regulations;
3) The next two years (1975-1976) in which the FNS moved into the new hospital and made major changes in its services in compliance with these regulations.

These three periods are presented below in relation to cost factors:

1) Cost Factors of the First Forty Years:

During the first forty years the FNS service costs were kept low by employing the nurse-midwife, as the major primary care provider, in preference to the physician. During this period she was the only prepared primary care nurse available for this type of service and could be employed at lower costs. Medical technology was maintained at a very simple level; laboratory work consisted primarily of hemoglobins and urinalysis, and the collection of specimens (e.g. blood, feces, and throat cultures for specific diseases) which were sent to the State Laboratory and were processed without cost to the patient or the agency. Use of blood transfusion and veni-puncture were rare and performed primarily at the hospital. Drugs used were also much less complex. In the early days antibiotics were not available, and the FNS relied more on empirical and generic drugs. Hospitalization or institutionalization of patients was not common practice, since such care was most inaccessible and few people could afford the expenses.

Medical technology related to childbirth services similarily was not extensive. Deliveries were conducted in the home unless problems in delivery were anticipated. This created a major saving in hospitalization. The family was responsible for most of the supplies for the delivery. A minimal amount of drugs, or laboratory work were used. No anaesthesia and less medications were used for a normal delivery. Episotomies were rarely performed. Charges were $5 for prenatal, postpartum and delivery care.

For comprehensive service the family paid a $1.00 annual fee for nursing care, and the cost of the drugs used for adults. There was a small fee for physicians' service to adults. If hospitalization was required charges for sick care were minimal. Payment was often in-kind. The entire cost of care was not carried by the patient. The costs of operations were therefore kept at a minimum. No State or Federal funds were available to support services, and philanthropic funds were difficult to raise.

The nurse-midwife, the registered nurses, the physician and the social worker were the only health professionals employed. The physician, social worker and the registered nurses were situated at the hospital. The nurse-midwives were located at both the hospital and the nursing outposts (P.C.H.C.).

The nurse-midwives functioned as primary care providers for the total family in accordance with the Medical Directives. They managed the drugs and the laboratory procedures. In Hyden Hospital they were also the x-ray technician, and performed other medical technological tests such as EKG's.

In district the nurse-midwife did her own paperwork, which was at a minimum. For support personnel she had a maid and a maintenance man for the up-keep of the clinic, which was residential. If necessary the nurse could provide overnight care to the patient in the district clinic. The maid was available to take calls when the nurse was making home visits.

Staff at the Hospital was also kept to a minimum. Hospital personnel included a nurse-midwife superintendent, the nursing staff, a secretary, and dietary and maintenance personnel.

The nurse-midwifery school, which graduated 12 students a year was located at the hospital. It was conducted by three nurse-midwives who together with the students managed the midwifery services at Hyden Hospital and in Hyden District. Administrative personnel included two assistants to the Director, two secretaries, a statistician and a post mistress. A small staff of volunteers, the couriers, supplemented personnel needs. There were no aides or L.P.N.'s as such, though couriers often assisted in patient care. Careful, but minimal records were kept of all services provided. Supplies were maintained through the central office for the district clinics. The hospital maintained its own supplies.

Services were much less complex and administration less chaotic, than at present. Working overtime was not uncommon but certainly considered less as a 'problem'. State and Federal regulations were minimal thus the agency functioned in a relatively autonomous manner. Nurse-midwives were licensed through the State, as were physicians and registered nurses. Regulations governing the hospital were relatively simple.

Throughout the FNS history health care revenues have been one of the major factors influencing the nature and type of services provided. One of the factors was the income of the area. The median family income in 1930, Willeford (1932), was $566; median per capita income was $114. In 1970, per capita income was $895 per annum. This means that the area in and around Leslie County never was able to maintain a technically sophisticated health agency. During these years, the service was maintained primarily through donations. Salaries for employees, except in the very beginning, before the 'depression' were very low, as were the costs of living. In the nursing clinics even telephones and radios were luxuries. Refrigerators and bathrooms were considered a necessity. Few families had either.

Because of the costs and the inaccessibility of medical care, heavy emphasis was directed toward preventive care, as well as general health. Environmental teaching and counseling, with greater emphasis on self care was the general approach. Families were responsible for most of their own nursing care, except when serious illness occurred. For example, the nurse rarely provided day-to-day bedside care for the sick in the home as may be presently done through the Home Health Nurses if the patient is on a plan of care. The aim then was to prevent costly curative care. Annual specialty clinics were conducted at the Hyden Hospital. In the interim specialty care was provided through the private clinics in Lexington and the University of Cincinnati Medical Center. Transportation was a major problem for both the agency and the families in the community. Ambulances were non-existant; in recent years a local funeral home has provided some emergency transport services.

The infant and maternal mortality rates, one of the indices used for the measuring quality of health care, was well below State and National rates as noted earlier. This is confirmed by the Metropolitan Life studies (1952). The care provided might not be considered ideal, but it was practical and economically feasible for the times. This was achieved with minimal modern medical technology. Simple tests like the testing for Rh factor were introduced at minimum costs, as such technologies became available.

It was the changes in transportation, electrification and the communication system which created the avenues for introducing new medical technologies that contributed to rising costs. Leslie County received its first rural electrification in the late 40's; and jeeps began to replace the horses in the early 50's. But such changes in the beginning were very gradual. It took time to build roads. The Interstate which comes within 50 miles of Hyden was not completed until 1968. The Daniel Boone Parkway leading to Hyden and Hazard was completed in 1974. Even now many of the county roads are still hazardous. These are only some of the factors that initiated change. National movements concerned with civil rights and poverty were other pertinent factors. These were largely external forces, that were slow to reach this area.

The demographic factors which isolated this area, as well as the economic status changed slowly. As a result the manner in which health care was provided changed little until 1965. At that time the operating budget of the FNS for the Hyden Hospital, including the outpatient department and the nurse-midwifery school, the seven district nursing stations, and the Administrative Center, was $300,000 per annum. The average cost of health per individual per annum was approximately $20.00 for an estimated population group of 15,000.

2) Cost Factors of the 1965-1974 Decade:

Events which spearheaded the changes of the 1965-1974 decade, which led to further increases in costs, were largely induced by external factors and the development of new medical technologies. These were, however, very closely interrelated. The introduction of Medicare/ Medicaid in 1966 was largely an external factor which instigated, and made possible many of the other changes. Some were advantageous, others were not. Family planning, an addition to comprehensive services, was a new medical technology that was introduced concurrently. It helped reduce the birth rate by half in 5 years in Leslie County, Beasley (1972). Family planning was introduced without major expenditures of funds. New technologies involving EKG's, laboratory and x-ray were more expensive.

One of the first elements of operation that the FNS had to change was the introduction of new methods of accounting and reporting; the development of a third party billing system; and the modification of policies to meet new rules and regulations to qualify for third party reimbursement. These were not only confusing but restrictive. They required major addition of new clerical staff and administrative assistants. All were increased cost items.

The greatest changes that occurred as the result of Medicare/ Medicaid, was related to the addition of more physicians on the staff. This was necessary to meet Medicare/Medicaid requirements. This created greater "demands" for laboratory, x-ray and other medical technological equipment, facilities and manpower. The new facilities were planned and built during this period. Funds for these developments were kept separate from the operating costs. Expansion of staff in anticipation of the change was initiated. These were included in the operating budget.

During this period the FNS also sought and received funds for the study and the development of the family nurse program. This was an effort to broaden the preparation of the nurse-midwife and increase her capacity to meet total family health needs. The demands for nurse-midwifery services _per se_ were decreasing through the family planning program, as noted earlier. Medical manpower shortages in rural areas were increasing, as confirmed by the Booz-Allen Hamilton Study (1969). The shift in training to include family nursing was considered essential to meet changing needs. However, it led to the need for more space, and research to document both the service and educational activities. All contributed to the continuing rise in costs.

These increases in cost have to be assessed in the context of their impact on service. Cost factors related to regulations led to a gradual shift from a health care model that was largely preventive oriented, family-centered, and community-based to a more curative and medically-oriented, office-based service, that centered more on the individual. Health care visits at the hospital clinic are more costly than those offered in the community clinics, as noted earlier. Both the salaries of the provider and the costs of treatment were lower in district, Moscovice (1976). Findings suggest that these changes did not necessarily result in an improvement of the outcome as suggested by the increase in infant mortality. This is not the only indicator to be considered.

By 1974 the operating budget had risen to $1,500,000 per annum. Unfortunately no cost analysis is available prior to 1974. As noted earlier, there was relatively little change in the number of visits or the rate of hospitalization throughout this period. School enrollment however was doubled and research broadened. Training and research grants, made available through Federal funding, are included in the operating budget. The five-fold increase in the operating budget during the 1965-1974 decade was therefore related primarily to the increase in operational cost of the services, and increased educational and research activities. While many of these operating costs were related to more stringent rules and regulations, inflation was a major external force that further led to increased operating costs Zubkoff (1976).

Hospital reimbursement was discontinued in May 1973 because the hospital was declared a fire hazard by Medicare standards in spite of FNS efforts to correct the deficiency in accordance with State requirements. The FNS was, however, able to maintain its services, but it created a major financial burden for them. This discontinuation of reimbursement was contested by the FNS, but not resolved until

1977. This was an important repressive factor in maintaining costs, as was the inability to get equitable reimbursement for the services provided by the primary care nurse.

3) Cost factors of 1975-1976:
The same factors which led to increasing operating costs in the previous decade were carried through during the two following years, 1975-1976. The increase, however, was further accellerated by the opening of the new hospital and the introduction of more stringent standards for quality of service and compliance with governmental and private regulatory agencies, e.g. State Licensure's and survey teams for the Hospital, the Primary Care Agency and Home Health, the Joint Commission on Hospital Accreditation, the PSRO system, and the accreditation of the nurse-midwifery and family nursing programs. These applications, surveys and reports are all time consuming and costly. They require a high level of administrative and staff input. The cost benefits need to be related to the amount of time as these procedures detract from direct service and education.

The major increase in the operating budget during this period was related to the opening of the new hospital in 1975. The operating costs of the hospital in 1976 was equivalent to the cost of the total FNS operations in 1974, as noted in the Cost Analysis Table XXXI.

This table shows the cost of operation for each of the service areas during 1976 calendar year according to direct and

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allocated costs. This includes patient and other revenues. Approximately half, or 51% of the operating budget is for hospital care; 19.1% is for the hospital outpatient care (or the Primary Care Medical Center); 11.3% for the Primary Care Health Clinic; and 4.2% for Home Health. (The Home Health Agency was not established until August 1976.)

Average cost per hospital day is $179.26 which includes medical, dental and social services. This is within average range for community hospitals in the Southern region, but lower than the $194.85 average cost per hospital day in Kentucky (Kentucky Health Care Statistics, 1975).

Average cost per P.C.M. Center visit is $18.32. Average cost per P.C.H. Clinic visit is $16.50. If broken down into clinic and home visits the estimated costs are $11.78 per clinic visit and $28.00 per home visit. Average costs per home health care visit is $33.21. This includes extensive nursing care and is limited to the homebound patients on medical plans of care.

According to this cost analysis primary care health clinic visit costs are substantially below P.C.M. Center visit costs. While only 36.3% of the outpatients were made at the P.C.H. Clinic it is estimated that approximately 62% to 67% could be managed at the P.C.H. Clinics; that approximately 13% require home health care and that 20% require P.C.M. Center services. The study by Moscovice ([illegible]) showed that district clinic visits for the care of pharyngitis/tonsillitis and U.T.I.'s were lower for three reasons; a) the salary of the provider; b) the use of laboratory tests; and c) the lower cost of the treatment, (the Direct Costs) as noted in Table XXXI. Allocated costs (administrative, depreciation, insurance and maintenance).are also substantially lower. It should be noted that P.C.H. Clinic visits markedly reduce transportation and time costs for the patient as well.

Average cost of outpatient services are not available for surrounding areas for comparative studies. According to "Report of Services Rendered by the Kentucky Medical Assistance Program", average costs of reimbursement per Medicaid recipient for Fiscal Year 1973-1974 was $82.20 in Leslie County, $262.26 in Perry County (an adjacent county), and $229.78 for the total State. Hospitalizations were $12.60; $120.97 and $76.08 per recipient respectively. Physician fees were $16.20; $51.85 and $33.80 per recipient. Comparable figures are not yet available for 1976.

This would indicate that overall costs in Leslie County are still substantially below State costs. The lower costs are related partially to the reduced costs of the P.C.H. Clinic visits, but more substantially by the reduction of costs through decreased hospitalization.

The study by Gordon and Isaacs (1976) showed that the hospitalization rate for the diabetic was 70% below the average for this area. Statistics indicate that hospitalization at the

FNS for all chronically ill patients is approximately 70% below that for this region. This creates a major saving since hospital care is now an average of $179 per day, while home visits are $33.21 per visit. The average homebound patient requires an average of 4.7 visits per month or just slightly over 1 visit per week. This results in major savings to the institution and the patient.

Statistics for nursing homes are not available. The nearest nursing home is approximately 80 miles away and used primarily when home care is unavailable or difficult to maintain, which is relatively rare. In 1974 the local Welfare Department estimated that there were approximately 12 Leslie County residents in nursing home facilities.

The extent to which this reduction in hospitalization and nursing home care is achieved through home health services, or the decentralization of the preventive and maintenance services provided by primary care nursing can only be surmized. But it should be noted that surrounding areas, used for comparison, have home health services, and that Runyan (1976) was able to demonstrate similar reductions in the hospitalization of the diabetic through a decentralized primary health care service similar to those provided through the FNS.

The Tables XXXII, XXXIII, and XXXIV provide information regarding the pay source according to site, provider and category of service. While they are of interest, they do

TABLE XXXII

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Number of Visits in a Month According to
Patient's Type of Pay Source - Monthly Average 1976

	GRAND TOTAL	GOVERNMENT THIRD PARTY			OTHER THIRD PARTY				PRIVATE PAY	OTHER
		KMC	Med. A	Med. B	WC	BC/BS	SLU	Other		
P.C.M. Center	2606	817.5	21.5	36	32.5	445	165	128	841	120
P.C.H. Clinic	1650	202	87	4	2	2	20	5	999.5	328.5

	GRAND TOTAL	GOVERNMENT THIRD PARTY PAY SOURCE		OTHER THIRD PARTY PAY SOURCE		PRIVATE PAY		OTHER	
		Number	Percentage	Number	Percentage	No.	%	No.	%
P.C.M. Center	2606 100%	875	34	770	30	841	32	120	4
P.C.H. Clinic	1650 100%	293	18	29	2	999.5	60	328.5	20
TOTAL	4256	1168	27.4	799	18.8	1839.5	43.2	448.5	10.6

P.C.M. Center = Primary Care Medical Center
P.C.H. Clinic = Primary Care Health Clinic

*Other see Table XXXIV

TABLE XXXIII

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Percentages of Charges According to Type of Service and Pay Source - Average Monthly Percentage for Calendar Years 1975 and 1976

	GOVERNMENT THIRD PARTY		PRIVATE THIRD PARTY		PRIVATE PAY		OTHER**		TOTAL	
CATEGORY OF SERVICE	1975	1976	1975	1976	1975	1976	1975	1976	1975	1976
	%	%	%	%	%	%	%	%	%	%
Physician	39	48	26	26	24	22	5	4	100	100
Primary Care Nursing*	12	5	24	41	59	51	4	3	100	100
Drugs & Solutions	25	26	36	34	38	34	1	[illegible]	100	100
EKG	76	46	16	26	8	28	0	0	100	100
Laboratory	42	33	23	31	30	29	5	7	100	100
X-ray	29	41	29	29	28	23	14	7	100	100

*Includes Nurse-Midwifery and Family Nursing Services

**Other - Operating room fees, special procedures, social services, transportation, physical therapy

TABLE XXXIV

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Distribution of Charges for Service by Category of Service for One Month Sample - 1976

CATEGORY OF SERVICE*	GRAND TOTAL	GOVERNMENT				PRIVATE THIRD PARTY					PRIVATE		OTHER	
		TOTAL	KMC	Medicare A	Medicare B	TOTAL	WC	BC/BS	Other	SLU	TOTAL	Private Pay	TOTAL	Other
Physician Percentage	16893 100.0%	8174 48%	7090	177	907	4330 26%	127	2332	701	1170	3724 22%	3724	645 4%	645
Primary Care Nursing	2527 100.0%	240 9%				1380 55%					1087 43%	1087	12 0%	12
PROCEDURES Laboratory	5446 100.0%	1820.5 33%	1499	32	289.5	1674 31%		1129	254.5	290.5	1598.5 29%	1598.5	353.5	353.5
X-ray	3350 100.0%	1363 41%	1155.5	37.5	170	974 29%	52.5	464.5	155	302.5	777.5 23%	777.5	235 7%	235
EKG	595.4 100.0%	275 46%	160	30	85	157 26%		92.2	45	20	163 28%	163	0	0
Drugs & Solutions	1412.6 100.0%	331.6 23%	312.1	12.5	7.0	477.4 34%	3.3	295	56.5	122.6	545.6 39%	545.6	11.2 1%	11.2

*Other services not included e.g. operating room fees, special procedures, social services, transportation, physical therapy not present any clear pattern of reimbursements. The only striking finding is that physicians provide a substantially higher percentage of the services to the Medicaid/Medicare patient. The primary care nurse is more apt to provide care to private pay patients and those patients who are covered by other third party payors. These tables are somewhat misleading because pay source is listed only according to the categories of care which are covered through these sources.

Conclusions:

Because economics are related to so many factors other than costs, one can draw only limited conclusion from these findings. The only definitive statements that can be made are that primary care nursing visits in the district are less costly than hospital clinic visits; and that hospitalization which is costly can be reduced through decentralized primary care services.

The data presented clearly indicates that the type of care provided is influenced very significantly by the pay source and/or the reimbursement system, and the accompanying rules and regulations. The degree to which these reflect health care needs, determine type of care provided, or the patient's decision to seek care where he will not be billed, cannot be determined by this study. Indications are that each plays a part in the selection of care. Furthermore, it is acknowledged that the providers consider the patient's ability to pay, and the hardships that will be created, in planning diagnostic and therapeutic procedures to be used. Patients with third party coverage, or those who are more affluent are more apt to select what they consider the best care available. For these reasons it is most difficult to rationalize costs according to pay source, particularly when there are so many variations in the regulations regarding what each will cover.

New studies would need to be conducted to determine if there is greater consumer satisfaction in these areas. Local people are currently more vocal about the shortcomings than improvements so this would be difficult to measure. Marion Pearsall's study (Appendix H) indicated that local persons who used local health services were most satisfied with the services provided through the district clinics. Patients still list the same reason for preference of the district clinic. There patients are more apt to see the same provider. They do not have to wait as long, and the practitioners are less apt to "put them down". Furthermore, they feel the nurse in the district clinic has more time, and if necessary will refer her to the physician. If they need medical care they will go to the hospital clinic. This suggests that improved technology and additional personnel has not necessarily led to improved consumer satisfaction.

Final Comments:

Reduction of infant mortality, or increased longevity, in itself, cannot be translated into financial savings. This is particularly clear in a society that emphasizes zero population growth, early retirement. It is complicated when unemployment rate is high, and care of the sick and the deceased through funeral services have become lucrative businesses providing excellent sources of income and employment.

3. Training Costs:

Cost of training is difficult to separate from service costs in an agency that offers both service and training. This is complicated because the trainees provide service as part of their training and staff spend a significant portion of their time supervising students. Efforts have been made to separate school and service budgets, though this has been difficult because of the overlapping.

Classroom teaching and educational school administrative activities by staff and faculty are reflected in the School Budget (See Table XXXI) according to periodic time studies, while all clinical and service activities are included in the Service Budget. This includes clinical supervision of the student by staff since this involves clinical activities, which can be reimbursed through third party payors. The services offered in-kind by students are not reflected in the service budget, since under present regulations the FNS cannot seek third party reimbursement for these services. On the other hand, according to Table XXVIII students manage 21.4% of patients receiving primary care on an outpatient basis, and that they see an additional 10.8% of patients together with the physician and a primary care nurse graduate. In these situations the trainee generally does the diagnostic work-up, and may perform a major portion of the planning and therapeutic procedures. However, unless the physician sees the patient directly no third party claims may be sought. This involves 4.2% of the patients seen by physicians. For this reason it is most difficult to assess the contribution made by the school to service. Albeit, on the basis of Table XXVIII, this contribution is significant.

Table XXXV indicates the hours and the percentage of time the faculty and teaching staff spend in educational functions (teaching, preparation, administration and clinical supervision). As is noted, average amount of time spent by faculty or teaching staff in educational functions is less than 50%. It ranges from 24.9% of time by family nursing staff, to 30.3% of time by the medical staff, and 43.5% of the time by the nurse-midwifery staff. Of the time spent in educational functions 60.7% of the time is spent in clinical supervision.

According to Table XXXI on Cost Analysis, the Educational and Research Budget shows that direct costs are $272,655 per annum. This includes salaries, supplies, library and audiovisual supplies, and other expenses. Allocated costs are $163,633. This includes the administrative, depreciation and maintenance costs. Housing for students, which is maintained by the FNS is included. It should be noted that some students seek and rent their own housing.

TABLE XXXV

FRONTIER NURSING SERVICE
Hyden, Kentucky 41749

Percentage of Total Hours Spent in Each Educational Function According to Category of Provider - 1976 and 1977

TYPE OF PROVIDER	TOTAL HOURS	CLASSROOM	PREPARATION	ADMINISTRATION	CLINICAL SUPERVISION	
Family Nursing	24.9%	19.6%	12.3%	18.5%	49.4%	100%
Medicine	30.3%	14.5%	15.7%	8.7%	60.7%	100%
Nurse-Midwifery	43.5%	6.5%	8.5%	16.0%	68.7%	100%
Other	1.2%	27.0%	24.2%	48.5%	0	100%
PERCENTAGE	100.	12.5	11.9	14.8	60.7	100%

If they are scholarship students they receive a set sum toward the rent.

Approximately $65,000 of the operating budget is spent on the research program which was initiated through the Primex Grant. This leaves an operating budget of $371,288 for the educational program. With an average enrollment of 30 students per year, the average cost per student, which includes housing, is $12,376.27.

The revenue is $366,407. This covers all but $69,881 of the operating cost of the educational and research programs. The revenue includes the teaching grants, the tuition and fees, scholarship funds, rent and stipends. (Interns are paid a $400 monthly stipend.) Stipends and stipend funds are received from private foundations.

The amount of costs contributed by the FNS to the education and research program is $69,881. Taking into consideration the amount of service contributed by the students, which would require additional staff, the school contributes more to the FNS than FNS contributes to the school. On the other hand, the FNS cannot collect reimbursement for the services provided by the students, and reimburseable costs are expended in the provision of these services. These costs are currently carried by the School, since they are essential for student experience.

The cost of $12,376.27 per annum in 1976 for one full year of professional education for the family nurse is not significantly higher than the median cost of $10,925 per graduate of the Family Nurse Certificate Programs as noted in the Nurse Practitioner and Physician Assistant Training and Deployment Study (1976). It should be noted that the FNS program was the only family nurse program that offered one full year of classroom and clinical teaching. The costs of the internship is included in total costs. Therefore total estimated costs of training a family nurse was $16,499.64. With the discontinuation of the internship the cost per trainee should be proportionately reduced.

4. Demonstration and documentation of the role that an organized rural primary care education and service center can play in the health field.

It has been well documented and demonstrated in this report that a rural primary care center can play an important role in defining and establishing a new role for nursing in the provision of primary care. Furthermore the quality of the educational program conducted in a rural service agency can adequately meet the criteria established for University programs that provide similar training, as noted in the ANA Accreditation site visit report. (Appendix L)

a. Formulating more feasible and practical approaches to health care:

One of the most important factors documented by this study is the system of health care delivery. This system combines aspects of the more traditional health care system with the more decentralized family-centered, community-based health care centers. The hospital clinic, which functions as a primary care medical center provides the more traditional medical and supportive service i.e. x-ray, laboratory, and other diagnostic and therapeutic services. It is different in that the physicians see a much smaller proportion of the patients and other health providers manage a much larger percentage of the care with the primary care nurses providing the greater proportion of direct patient care.

The primary health care clinics which form the nucleus of this system are staffed by primary care nurses, who provide the bulk of the day-to-day health services. It is in this respect that this primary care system differs so markedly from the more traditional office-based care. This system is also much more closely coordinated with other services located within the community, the region, and the State, which provide specialty and/or tertiary care services and health related services (private and governmental).

Each has a very distinctive role to play in the total scheme of health delivery services. What is distinctive about this system is the greater focus on preventive and health maintenance care through the primary health care clinics. This encourages family and community responsibility in their own care by promoting appropriate health care practices. It also encourages home care of the sick where possible. This helps strengthen family cohesiveness.

An important aspect of this program is the primary health care nurse, who working as a generalist and patient advocate, provides an avenue for channeling the patient to the other health, medical, and social services as needed. This is most important in a rural area which is relatively isolated, and in a social system in which health care services are becoming increasingly complex and compartmentalized.

It has inherent in it many of the problems of the traditional system, such as the isolation of the practitioner. This is, however, less apt to happen if the agency places heavy emphasis on continuing education. It is subject to the same regulatory system that faces other organized health care agencies, but in a system such as the FNS has developed, administration assumes the major responsibility for the coordination of these policies within the system, and for negotiations with the regulatory bodies. This relieves the health care provider of many of the administrative details associated with the regulations, accounting, billing, and other administrative functions including purchasing and other maintenance functions.

It should be noted, however, that compliance with regulations is one of the factors which has contributed to

> the rise of health care costs, and contributed to the complexities of health care management. Simplification of this system is most urgently needed.
>
> Urgent, too, is the development of a financial system, which recognizes the contributions made by the primary care provider.
>
> Professional recognition through credentialing is another major problem that must be resolved if this system is to continue.
>
> These three issues (regulations, financial reimbursement, and professional credentialing) have absorbed a large portion of staff and administrative time and effort. They have detracted from the time and effort that could be directed toward the development of a workable and practical approach to health care, and from the opportunity to freely experiment within this system.

Because the education program was established within a primary care setting administered by the same administration, it had the extra advantage of molding and being molded by the service agency, which stimulated the formulation of new conceptual approaches in both service and education. The interchange that occurred was very stimulating and it instigated the development of a very practical approach to service research which has become a part of the billing research and planning program.

This has made possible more specific alignment of functions and goals to be realistically attained, as well as the development of new proposals for funding and assessing health care services. The research activities have demonstrated a relatively simple method for collection of data which helped document the possibilities of reducing health care cost and improving health care outcomes through a decentralized approach to primary health care.

In addition this report portrays the advantages of a well coordinated system that addresses itself to the total spectrum of health care, through community and consumer participation, its own service and education program, and through specialty care and academic linkages. These are not unmixed blessings.

b. Health manpower recruitment and development:

The FNS has also demonstrated new potentials for recruitment of health manpower and the development of primary health care manpower for rural primary health care.
The ability to recruit manpower for service and educational purposes from across country and abroad signifies a growing interest in the concept of primary care as it is being taught and practiced. A vast number of visitors have come from many states and countries with the hope of returning to their own area to develop similar programs.

The FNS can no longer begin to accommodate all applicants for the school or the service.

c. Renewal of interest in rural primary care services:

The role which the FNS has played in stimulating interest in rural primary care services is legendary. That others can do the same is without question. However, there have been many extenuating circumstances that have stimulated this interest. The growing awareness of a major gap in health services which swept through this country in the 1960's, and the political and social interests in poverty areas all played a part in creating new interests in primary care, particularly as this might help meet the needs of rural and other medically underserved areas.

This increased interest in rural health is particularly evident in recent legislation, such as P.L. 94-641, Senate Bill S. 708, and House Bill H.R. 2508. These bills are the culmination of many efforts designed to promote the type of rural health care to which this project addresses itself. While this legislation addresses itself to Medicare reimbursement only, it will hopefully provide a stimulus to other third party payors and eventually provide new incentives for new national health care policies and insurance.

d. Linkages with specialty care and educational institutions:

These are readily developed when there is an established primary care service and training agency in the rural area. However, because of the wide gap between academia and service, early ventures were often awkward. The primary care agencies are often hesitant to give up their autonomy and find it difficult to break down or accomodate themselves to the well established criteria and standards of academic. Academic institutions experience similar difficulties.

Specialty care agencies are prone to accept the patients referred so they might take care of them, with little thought of problems encountered in transferring the patient back to his home and family, and assuring continuity of care through the primary care agency. Many new and exciting relationships were developed as each learned from the other in the resolution of these problems. These early linkages have created many new outreaches into rural areas, and established new bonds and avenues for sharing and assisting each other in the management of rural health and health manpower training. Constant efforts must however be expended to keep these relationships alive and functioning.

To document and demonstrate rural primary care at a time when most people thought of rural health as being very thankless and uninteresting drudgery which most enterprising young women or men would shun, has made the new interest that has developed a gratifying process. It has been particularly satisfying to see young men and women take a new interest in other social and cultural groups and develop a new role for themselves, and their profession. In the process many developed a leadership role for themselves, and made it possible for others to engage in new roles in the health field.

IV. RECOMMENDATIONS AND SUGGESTIONS:

Many changes in national health policies and manpower training have been introduced as a result of the primary care training projects supported through NCHSR. These include legislation (passed and proposed) pertaining to the promotion of primary health care, e.g., the HSA's; reimbursement for Medicare in rural health clinics (Senate Bill 708 and H.R. 2805); State Licensure for Primary Care Agencies (Kentucky Regulations for Primary Care); and federal funding for primary care training. Also included are national accreditation of primary care training programs and certification by examination of its graduates through the respective professional organizations; and the development of State and National organizations for interdisciplinary promotion of primary health care. All these actions are commendable. Additional changes are however needed to further facilitate primary health care training and the delivery of primary health care services.

The following recommendations are presented for consideration, since each requires national action to facilitate their development and implementation at the grass root level:

A. MANPOWER DEVELOPMENT:

1) The development of primary care research and development centers within primary care agencies are

essential for providing opportunities for coordinating service, research and training activities at the practical level, and to provide opportunities for service-oriented learning.

These centers should include training in family-centered, community-based health clinics that provide both clinic and home care. It is essential that Primary Care Management training also be developed within these centers for planning and administrative personnel. Such centers are essential for the development of new knowledge in primary health care, and to prepare practitioners, planners, and administrators who are familiar with the problems they are expected to manage. The aim should be to promote interdisciplinary and joint practice, training and research.

The proposed primary care centers should be designed to provide national models for primary health care development. They will require federal financial support.

2) The development of modules/core curricula through a National Committee to serve as basic guidelines for development of content to be mastered within primary care programs, (as examplified in Appendix L) is strongly recommended. The modules/core curricula should include content that is considered essential for Primary Care functions, as well as elective content.

Elective modules should be available for continuing education or as part of the basic program. Basic content should also be available for continuing education/review for former graduates. These modules/core curricula should be designed to facilitate modification/expansion to meet the needs of individual programs, the needs of the area in which the training program is located, e.g. rural/urban, and special health care problems as they occur in different geographic regions.

3) The development of strategies for closer linkages between University and Service Training Centers are recommended. These should be designed to promote greater sharing in program development and teaching without threatening the autonomy of either, or duplicating teaching efforts and costs of training. Both can contribute a great deal. These strategies should preferably be designed by a National Committee to serve as basic guidelines. Both service and university staff (teaching and service) and administration should be represented on such a committee.

4) The development of a mechanism for granting nationally accepted academic recognition/credit for the content mastered is recommended. Such recognition/credit should be granted on the basis of program accreditation by the respective organizational

accrediting bodies, (e.g. A.N.A.) as long as the program meets established educational standards.

Such recognition should preferably include a degree or a certificate together with academic credits in primary care, (e.g. for a nurse it could be a P.C.N., primary care nurse; for a physician assistant it might be a P.C.P., a primary care practitioner or a P.H.C.P., a primary health care practitioner).

This training program could be part of a bachelor or Master's program or it could be offered through a certificate program. This would not preclude licensure, but provide a basis for licensure.

B. LEGAL RECOGNITION:

The development of a National Licensing Body for Primary Health Care practitioners should be given serious consideration. The lack of National Licensure for Nurse-Midwifery has been most problematic. There are still many states in which it is most difficult to establish nurse-midwifery services. The lack of National Licensing mechanisms has created major problems for the individual practitioner, health agencies, and communities who have attempted to improve health care services in medically underserved areas.

In many states such legal obstacles are raised by the more powerful health care practitioners to stymie the politically less powerful and less affluent groups. It can hardly be called a free enterprise or a democratic process. This problem can best be overcome through a National licensure body with State participation. Such a system would alleviate staffing problems especially among small agencies who are dependent on these mobile groups within the nursing profession.

A model for National licensure of other health care providers would be provided.

C. ASSURANCE OF QUALITY OF SERVICE:

A system for assuring quality of service should be part of any reputable health care agency. This can be incorporated at several levels:

1) At a local or agency level, which would consist of a record review as proposed in Appendix J. This should be based on the Health and Medical Protocols or Medical Directives used by an agency.

2) At the HSA Regional or state level. Quality assurance should consist of licensure of the Health Care agency and an annual assessment of local agency review system. As an example, the Kentucky Primary Care Regulations provide basic guidelines for such licensure.

3) At the National level, which should establish guidelines for the development and implementation of State/HSA licensure and review; and basic health and medical protocol/directives to be modified or expanded

to meet local needs. Such guidelines should include minimal standards with options for extension and experimentation.

D. REIMBURSEMENT FOR SERVICE:

1) Reimbursement for broad based primary health care is urgently needed. The legislation that is being introduced by Medicare (S. 708 and H.R. 2508) is exampliary. However, it needs to be extended to cover the total family. The separate services related to health care for aged from services for all family members is most inefficient in terms of costs, health manpower availability, accessibility, productivity, energy conservation (e.g. travel for provider and consumer), and conservation of time. This is particularly important for employees who have to take off time to seek health care.

2) It is recommended that National health insurance be phased in at the primary health care level, which can markedly reduce the need for other more costly health services as a step toward reducing health care costs. Subsequently, National health insurance should be introduced for Primary Care Medical services, followed by Primary Care Hospital services. Primary Care Hospitals should have separate accreditation standards from those established for Specialty or Tertiary Care Hospitals as proposed in Senate Bill 3661 by Max Baucus. The Specialty or Tertiary Care

Hospitals which are currently largely covered by third party payors should be the last to be included in a National Health Insurance Plan.

The aim should be to maximize utilization of each level of health care services and to assure resourceful planning. Certificate of need as developed in Kentucky is a beginning step in lessening unnecessary duplication of services, facilities and equipment. Reimbursement for health care should be limited to agencies meeting HSA/State criteria for Assurance of Quality Service, and based on the competencies of providers rather than their credentials, as proposed in Appendix J. A precedence for a proposed model for quality assurance has already been constructed by the quality assurance program for medical care in hospitals (AHA).

The budget-based reimbursement mechanism proposed by Senator Tim Lee Carter in relation to Senate Bill 708 provides the most practical approach to primary health care reimbursement. This system will enable small agencies to plan ahead and implement an orderly system for providing continuity of care. It will greatly lessen the burden created by fee for service billing. Furthermore, this mechanism is much less likely to continue pushing up the cost of health care. The costs of operating such health care clinics within the context of primary care medical centers are presented in the testimony for Senate Bill 708, Isaacs (1977).

E. QUALITY OF CARE RESEARCH AND STUDIES:

A National system for conducting studies focusing on outcome of health services, related to costs, are essential for providing data upon which methods of cost containment can be analyzed. The aim of such research should be to determine costs of the different methods of health care and their outcome, in order to establish cost-benefits of different approaches, e.g. preventive versus curative in the management of diabetes. Such data should provide a base for establishing priorities and planning health care services specifically related to primary care and preventive health services.

This outcome and cost data should be available to assist lay people, their families, the health care providers, and planners, educators and legislators in the decision-making process. This is important in relation to self care, the care of others, or local, state, or federal planning and legislation. These decisions should of course be tempered by social and cultural values; their sociological and psychological impact; and they should be equitable. These recommendations should facilitate rather than restrict program actions.

The national system for research and study of outcome should not preclude local studies, but rather enhance consistency of data. In fact, the National System for research should provide for H.S.A. and local participation. The methodology for studying outcome employed at the FNS, develops a very practical approach to such studies.

Careful consideration must be given to research costs, staff time, individual rights, and the dissemination of information to avoid undue "interference" with the delivery of health care.

The total aim is to maintain a balance between the different segments of health care, education/training, and research; and to maintain a balance between health care and other priorities related to living.

These recommendations would markedly lessen the groundwork that each primary care service/training institution would need to perform, without corroding the initiative of the individual and his decision-making process. Each recommendation is considered vital as a means for responding to the needs and demands of individuals, families, communities, and programs, at a personalized level.

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APPENDICES

Appendix A: Frontier School of Midwifery and Family Nursing Catalogue

Appendix B: Organizational Chart, Frontier Nursing Service

Appendix C: The Management Approach to Care

Appendix D: The Team Concept at the Frontier Nursing Service

Appendix E: The Use of Drugs at the Frontier Nursing Service by Registered Nurses With Specialist Training in Family Nursing and Nurse-Midwifery

Appendix F: Behavioral Objectives for the Frontier Nursing Service Training Program

Appendix G: A Sample Module used in the Frontier Nursing Service Training Program

Appendix H: Medical Beliefs, Past Experience, and Use of Health Services in a Rural Appalachian Community

Appendix I: The Encounter Form, A Review of Procedures and Problems Related to the PRIMEX Encounter Form in a Primary Care Setting

The Encounter Form Handbook

Appendix J: Meaningful Audit for Service-Based Versus Credential-Based Reimbursement

Appendix K: "Abstract" - Development of a Method for the Analysis of the Utilization of Resources in an Ambulatory Care Setting

Appendix L: American Nurses'Association National Review Committee Site Team Report - February 3-4, 1977

Frontier School of Midwifery and Family Nursing

A Primary Care Nurse Education Program
in Family Nursing and Nurse-Midwifery

Frontier Nursing Service, Inc.
Hyden, Kentucky 41749
Printed October 1976

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THE FRONTIER SCHOOL

OF MIDWIFERY AND FAMILY NURSING

> "He shall gather the lambs with his arm
> and carry them in his bosom, and shall
> gently lead those that are with young."
>
> Isaiah 40:11

HISTORY

The Frontier Graduate School of Midwifery was started in 1939 by the Frontier Nursing Service, Incorporated, as a part of its demonstration in the care of the mother and child in remotely rural areas of Kentucky.

When the Frontier Nursing Service began the use of nurse-midwives in the United States in 1925, the Service could secure a qualified staff in only two ways: by sending American nurses to Great Britain to take graduate training in midwifery and to qualify under the English or Scottish Central Midwives' Board's examinations, or by enlisting the services of British nurses already qualified as midwives under one of these Boards.

In the early years the Frontier Nursing Service offered scholarships to American nurses to go to Great Britain, and recruited British nurse-midwives, many of whom had midwifery experience in programs and areas similar to those encountered at the FNS. The debt of gratitude we owe to Britain is thus a dual one. Without the hospitality the great midwifery schools in England and Scotland extended to American nurses, and without the contributions of British nurse-midwives, the work of the FNS would have been balked at its inception, since the FNS in the beginning was solely dependent upon the nurse-midwives for the provision of primary care services. The first full time physician was not recruited until January 1, 1932.

When the Second World War started in 1939, a number of the British members of the FNS staff wished to return to their homes as soon as they could be released. Under war conditions it was not possible to continue to send American nurses to Great Britain for midwifery training. The Service had to put into immediate operation its plans for a graduate school of midwifery. With the support of the Board of Health of the Commonwealth of Kentucky and of the Medical Advisory and the Executive Committees of the Frontier Nursing Service, and the cooperation of our mountain committees, the Frontier Graduate School of Midwifery opened its first class November 1, 1939. It has been in continuous operation since that time. During its first thirty years the Frontier Graduate School of Midwifery graduated 350 nurse-midwives. Graduates are working not only in the United States but also in Canada, New Zealand, New Guinea, and in many countries of the Middle East, Asia, Africa, and South America.

The founder of the FNS, Mary Breckinridge, remained active director until her death in 1965. She had often spoken of starting a school of district nursing, as a companion program to the midwifery school. Senior members of the staff developed plans for a family nursing program, and by late 1969 they came forth with a development grant. The Appalachian Regional Commission approved the grant for the FNS to work with Vanderbilt University to develop a graduate program at the University for family nursing. At the same time the FNS developed a certificate program to prepare family nurses at the FNS. The name of the School was changed to the Frontier School of Midwifery and Family Nursing.

The Family Nurse Program was successfully coordinated with the Nurse-Midwifery Program. Together the programs prepared primary care nurses to work in rural areas. The first family nurse class was admitted in June 1970.

In 1972 the FNS received a four-year research grant from the National Center for Health Services Research and Development, HEW, to study primary care nursing education and service. In 1974 it was awarded a three-year grant by the Division of Nursing, HEW, to develop an affiliation with the University of Kentucky, Lexington, Kentucky. In 1975 the FNS was awarded a three-year Robert Wood Johnson Foundation Grant for regional expansion of its program.

By 1976 the Frontier School of Midwifery and Family Nursing had enrolled over 150 family nurse and nurse-midwifery students in its programs.

THE PURPOSE

The purpose of the FNS from the beginning has been:

> "To safeguard the lives and health of mothers and children by providing and preparing trained nurse-midwives for rural areas in Kentucky and elsewhere, where there is inadequate medical service; to give skilled care to women in childbirth; to give nursing care to the sick of both sexes and all ages; to establish, own, maintain and operate hospitals, clinics, nursing centers, and midwifery training schools for graduate nurses; to educate the rural population in the laws of health, and parents in baby hygiene and child care; to provide expert social service, to obtain medical, dental and surgical services for those who need them at a price they can afford to pay; to ameliorate economic conditions inimical to health and growth, and to conduct research toward that end; to do any and all other things in any way incident to, or connected with, these objects, and, in pursuit of them, to cooperate with individuals and with organizations, whether private, state or federal; and through the fulfillment of these aims to advance the cause of health, social welfare and economic independence in rural districts with the help of their own leading citizens."[1]

---

[1] Articles of Incorporation of the Frontier Nursing Service, Inc., Article III.

THE PHILOSOPHY

The FNS believes that health consists of three parts: physical, mental, and social, which are inseparable. If one part suffers, or flourishes, the other is affected; and to attend only one part is to neglect another. The family, likewise, consists of many parts, which makes family health care an intricate and varied procedure. The more knowledgeable one is of the various parts and their relationship to one another, the more effective the judgment one makes in the care of the family, and the individual.

The better equipped the family is, the better it can cope with life's problems; but help is needed by all during times of stress or crises. Health education and counseling, therefore, form a vital part of a well-rounded health service.

Families that live in stressful environment, whether in Appalachia, the inner city, or developing countries, need additional assistance to help them cope. This requires that health be closely coordinated with community development programs and that the practitioner concentrate on the social and mental aspects of health as well as on the physical.

Health care begins at home, and in its entirety, it is much broader in concept than that of the traditional health care pattern. It incorporates the concern for the overall well-being of the individual and his family, his life style, environmental safety, as well as the availability of organized health services.

It is our belief that nurses, who form the largest single segment of health manpower, and who have the necessary basic training, with adequate medical back-up, are the most reasonable resource from which to draw for the staffing of primary health care services. The primary care education required for family nurses and nurse-midwives must be developed mutually on a sound theoretical base, by nursing, medicine and other personnel involved in health care. The consumer should be included in planning and development as part of their participation in the management of their medical needs and health care.

It is the blending of nursing with selected medical and public health functions that makes the role of the primary health care nurse distinctive. By broadening the traditional nursing role to include basic diagnostic, management and preventive skills, the nurse becomes a very important and meaningful member of the primary health care team. But first and foremost, she remains a nurse; and as such, her most valuable contributions lie in her teaching, counseling, and caring roles in which she seeks to create an environment that is conducive to healing, whether in the home or an organized health service agency.

As a primary care practitioner, the nurse becomes an interdependent member of the health care team, who participates in all aspects of health care; service, planning, education and program development. This requires a high level of knowledge, trust and respect for the skills of the different members of the health care team; and the ability to communicate clearly and function in close collaboration with others.

It is our belief that learning is best achieved through the service-learning orientation in which the accomplishment of a needed task is integrated with educational growth.[2] Both the scope and relevance of learning is broadened when the student becomes involved in the provision of needed health services. Exposure to the day to day problems of living of the population served provides opportunities for testing acquired knowledge in a real life situation; and helps the student become more keenly aware of, and responsive to, the needs of the people served.

Faculty, staff and students alike, must be committed to participation in both educational activities and patient service. This approach enhances learning and improves the quality of patient care. Faculty cannot be effective teachers without practicing what they are teaching; staff cannot give quality care without continuing education; and students learn best when they have role models and are involved in relevant problem solving.

Learning is most effective when self-directed, with students assuming major responsibility for their own learning and for services rendered. This includes participation in evaluation for self-development as well as program development.

Self-care, likewise, is best learned by the individuals/families when the primary health care provider performs as a role model for the population served, with the expectation that the consumers assume appropriate responsibility for their own care.

The aim of primary health care is to bring health services back into the mainstream of day to day living; to help individuals and families assume increasing responsibility for their own health care; to make health care more accessible at more reasonable costs; to integrate physical, mental, social health care; to correlate primary and specialty care; and to lessen the rate of hospitalization and needless institutionalization.

Research activities are an integral part of the total program. Research findings and their documentation are essential for sound growth and development of service and education.

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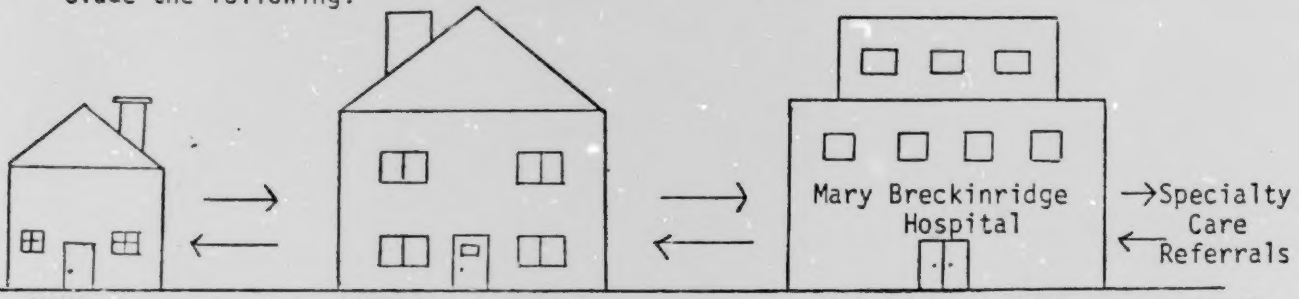
[2] Atlanta Service Learning Conference Report, May, 1970, Atlanta Service Learning Conference, c/o Southern Regional Education Board, 130 - 6th Street, Atlanta, Georgia 30313

A BRIEF DESCRIPTION OF THE FRONTIER NURSING SERVICE

The FNS is a voluntary primary care health agency, established in 1925. It operates a home health agency, an outpatient clinic, and a 40 bed hospital in Leslie County, and six district nursing centers located in Leslie, Clay and Perry Counties.[*] It also conducts a training program for primary care nurses--nurse-midwives (1 year) and family nurses (1 year) with an on-going enrollment of 30 registered nurses. Students may complete the combined program in 16 months.

Primary care services provided by the Frontier Nursing Service include the following:



HOME	DISTRICT CLINICS (6)	COMMUNITY HOSPITAL Health Center and Training Center	Regional and State Hospitals and Medical Centers
Population 16,000	Primary Care Nursing Services	Primary Care Nurse, Physician and Dental Services	Specialty Services
Certified Home Health 5 R.N.'s 8,000 Visits Annually (Home)	14 Nurses (11 F.N.'s and 3 R.N.'s) 20,000 Visits Annually (Home & Clinic)	7 Physician's[**] 8 Nurse-Midwives 8 Family Nurses 2 Pediatric Nurses 1 Dentist 2 Social Workers 15 R.N.'s[***] Ancillary Services: Lab, X-ray, EKG, ER, Physical Therapist, Pharmacy 32,000 Visits (Clinic) 1,600 Admissions (Hospital) 350 Deliveries	10% of patients referred for diagnostic work-ups and/or hospitalization. 6,000 referrals and/or consultations (FNS has 2 monthly specialty clinics---orthopedic and ophthamology, and an annual ENT outpatient and inpatient surgical clinic.

[*] Outpatient primary care is provided by teams consisting of:

1. Physician
2. Family Nurse/Nurse-Midwife
3. Family Nurse/Student Nurse-Midwife
4. Registered Nurse
5. Licensed Practical Nurse
6. Social Worker
7. Secretary

[**] Physicians conduct ½ day clinics in each of the district nursing centers.

[***] This includes 11.5 inpatient nursing staff.

DEFINITION OF THE FAMILY NURSE

The family nurse is a registered nurse who has successfully completed a recognized program of study leading to a certificate in family nursing. She is prepared to assume an expanded role in the provision of primary family health services. This includes: 1) assessment of the health status of the family and its members; 2) initiation of selected preventive, maintenance and curative health care measures, health education and counseling, using mutually (nursing and medical) agreed upon assessment, diagnostic and therapeutic measures; and 3) provision of emergency services in the absence of the physician. This includes consultation with or referral to other members of the health team, and planning, management and provision of health care measures commensurate with accepted practices and scientific advances. The nurse must also be prepared to delegate custodial care and other non-nursing health related functions to appropriate persons. Family nursing may or may not include nurse-midwifery.

DEFINITION OF THE NURSE-MIDWIFE

A nurse-midwife is a registered nurse who has successfully completed a recognized program of study and clinical experience leading to a certificate in nurse-midwifery. She is prepared to manage prenatal, intrapartum, postpartum care and family planning geared to the individual needs of each mother and family member. She cares for the mother during her pregnancy and stays with her in labor, providing continuous physical and emotional support. She evaluates progress and manages care of the newborn. She helps the mother to care for herself and for her infant; to adjust the home situation to the new child; and to lay a healthful foundation for future pregnancies. The nurse-midwife is prepared to teach, interpret and provide support as an integral part of her service. In a medically directed team, the qualified nurse-midwife may assume responsibility for the complete care and management of uncomplicated maternity and gynecological patients, referring and consulting with the physician when complications arise, applying appropriate emergency measures until the physician arrives, and sharing with him the care of abnormal or operative obstetrics.

THE TRAINING AND EDUCATION PROGRAM

The FNS, through the Frontier School of Midwifery and Family Nursing, offers a full-time training and education program in primary care for graduate nurses who are interested in rural health. The program is service-learning oriented, as noted in the philosophy, and may lead to three types of certification:

1) Family Nurse - three four-month trimesters

2) Nurse-Midwife - three four-month trimesters

3) Family Nurse-Midwife - four four-month trimesters

The Setting

Both the theoretical and clinical components are offered by the FNS which is a primary care service and training center situated in a relatively isolated rural area. The Service has extensive service and education linkages with other local, regional and state health care agencies and institutions.

The FNS operates a well-coordinated system for the delivery of primary health care. Home health services and nursing clinics are conducted by the nurses with team consultation; and the hospital clinics and inpatient services are conducted by the primary care team.

Linkages with the University of Kentucky Medical Center, which consists of five colleges (Medical, Nursing, Dentistry, Pharmacy and Allied Health) and other health care agencies help supplement the educational program and supply the needed consultation and referral services for specialty care.

Both the education and service programs share a common philosophy and administrative staff which help assure a well coordinated program.

Because of limited midwifery and family planning clinical material at the FNS, arrangements are made at Kingsport, Tennessee, and the Appalachian Regional Hospital, Letcher County, Kentucky, for additional clinical experience.

Objectives of the Training Program - To Develop Knowledge and Skills In:

1) History taking (physical, social and emotional) and physical examinations, utilizing appropriate diagnostic tools, tests and procedures for assessment of health and illness.

2) Recognition of normal anatomy and functioning for discrimination between the normal and the abnormal; and basic patho-physiology as a baseline for the management of common disorders and illnesses, as defined in the medical protocol.

3) Assessment of health status of individuals and family as a basis for health teaching, counseling and establishing appropriate plans of health care management.

4) Recognition of health risks -- biological, environmental, life styles and health organizations -- as a base for appropriate intervention.

5) Care and management of common health problems in the family involving all age groups, helping them cope with problems of health, illness and disability -- preventive, maintenance and curative. This includes management and care in fertility, reproduction, child growth and development, acute and chronic phases of illness, and other critical life problems.

6) The application of clinical skills in the home and community environment, and a variety of clinical settings, health care agencies and institutions, in collaboration with other health care providers and agencies in the planning, provision and management of health care services.

7) Systematic and accurate recording of assessment and management procedures and outcomes for critical evaluation and documentation.

8) Exploration of new approaches to the development, maintenance and modification of delivering health services in the home, the clinic, the hospital and the community.

The Program

The FNS offers four four-month trimesters in primary care.

The First Trimester (FN-IA) focuses on health assessment and management of the individual and the family. It is a prerequisite for all courses, and is not offered without plans for completing the family nurse/nurse-midwifery program.

The Second Trimester (FN-IB) focuses on diagnosis and management of common health problems in the family. It is a requirement for family nurse certification, and should be taken in sequence. Recommendation of faculty is required.

C.N.M.'s may be certified as family nurses upon satisfactory completion of FN-IA and FN-IB.

The Third Trimester (FN-II) focuses on prenatal, postpartum and neonatal care, family planning, and gynecology. It is a requirement for family nurse certification* with FN-IA and FN-IB as prerequisite. Recommendation of faculty is required.

The Fourth Trimester (FN-III) focuses on intrapartal care, obstetrical and gynecological problems, and the high risk mother and baby. It is a requirement for nurse-midwifery certification* with FN-IA and FN-II as prerequisite. Recommendation of faculty is required.

Please Note: Satisfactory completion of all four semesters is required for family nurse-midwife certification*.

*Certificates are awarded by the FNS upon satisfactory completion of program as noted above. (For National certification see page 20.)

OVERVIEW OF CURRICULUM

Family Nursing IA Adult Health Assessment Child Health Care Family Nursing Seminar Family Nurse Clinical Practicum I Principles of Human Physiology (University of Kentucky)	Family Nursing IB Assessment and Management of Common Health Problems (Child and Adult) Advanced Family Nursing Seminar Family Nurse Clinical Practicum II
Family Nursing II (Module Approach) Antepartal Management Postpartum Management Normal Neonatal Management Family Planning & GYN Management Introduction to Normal Spontaneous Deliveries	Family Nursing III (Module Approach) Intrapartal Management High Risk Neonatal Management

FAMILY NURSING IA

Adult Health Assessment

A clinical course designed to assist the nurse in developing a comprehensive approach to health assessment of the adult. Opportunity will be provided to practice beginning skills in history taking and physical examination and to employ basic diagnostic procedures in the assessment and management of health care. Four credit hours.

Child Health Care

A lecture/discussion course supported by clinical experience. The goal is to prepare the student to deliver primary and continuing care to children. Special emphasis will be placed on recognizing the individuality of each child, his membership within a family unit and the interrelationship of these two factors. Two credit hours.

Family Nursing Seminar

Concepts of health and methods of family assessment, health teaching, and clinical counseling in nursing are covered, including case materials. Focus is on theory and techniques for assisting individuals and families to cope with health risks, developmental changes, and related crisis situations which are linked with health status. Selected field and observational experiences are included. Two credit hours.

Principles of Human Physiology

A basic course in human physiology including the functioning and regulation of the major systems. It is offered by the University of Kentucky Department of Physiology at the FNS. Four credit hours.

Family Nurse Clinical Practicum I

The initial clinical practicum in family nursing is focused on a comprehensive approach to health assessment of individuals and families throughout the age continuum. Using problem-oriented recording, emphasis is placed on health maintenance and preventive care which includes counseling and teaching.

Each student is assigned to a primary care team, for clinical experience, as described on page 5.

A minimum of 24 hours a week are spent in the clinical practicum as part of the above course requirements.

FAMILY NURSING IB

Assessment and Management of Common Health Problems (Child and Adult)

Focus is on the family nurse practitioner's assessment and management of individual and family health problems (acute, chronic and emergency) commonly seen in a primary health care setting. Basic pathophysiology is included. Nine credit hours.

Advanced Family Nursing Seminar

Focus is on specific techniques of counseling and teaching needed to assist individuals/families in coping with illness and disability. A variety of health delivery systems, in which the family nurse practitioner can function, will be explored as well as current research related to primary care. Three credit hours.

Family Nurse Clinical Practicum II

Clinical practicum in the care and management of adult, child and family primary health care in a variety of settings. Under nursing and medical supervision, students will gain experience in assisting patients and families to cope with illness and disability. Problem oriented records are used to assist in the evaluation of services provided.

Each student is assigned to a primary care team, for clinical experience, as described on page 5.

A minimum of 24 hours a week are spent in the clinical practicum as part of the above course requirements.

FAMILY NURSING II

Nurse-Midwifery - Part I

Family Nursing II is a trimester designed to prepare the registered nurse to assume responsibility for the management of uncomplicated pregnant, postpartum women, normal newborns, and family planning.

The modular curriculum used in the teaching of nurse-midwifery is designed to encourage students to learn in their own way and at their own pace, within program limitations. Each module is made up of behavorial objectives for theory and clinical practice, with guidelines for mastery. Seminars are used to discuss clinical management. Individual conferences with instructors provide tutorial learning opportunities.

The FN-II trimester is divided into the following modules:

Antepartum Module

Theory and clinical practice in the care and management of pregnancy, learning to recognize and manage complications in collaboration with other members of the OB/GYN team. Comprehensive management is emphasized including the emotional and educational needs of the family. Five credit hours.

Postpartum Module

Theory and clinical practice in the care and management of mother and baby as a unit through the six weeks postpartum period, including teaching of health promotion and infant care. This module is designed to be offered concurrently with the Neonatal Module. Two credit hours.

Neonatal Module

Theory and practice in the care and management of normal newborns, from birth through six weeks of age, with emphasis on health promotion and infant-family relationships. Three credit hours.

Family Planning & GYN

Theory and practice in the care and management of the needs of families related to fertility and reproduction. Theory includes reproductive anatomy and physiology, human sexuality, contraception, and common GYN problems. Clinical experience includes initiation and follow-up of contraception; physical exam of healthy women between pregnancies, management of common GYN complaints. One credit hour.

Normal Spontaneous Delivery

Introductory theory and practice in the care and management of a normal spontaneous delivery. One credit hour.

Nurse-Midwifery Clinical Practicum I

For the clinical experience described in the above modules and courses, students are assigned to the nurse-midwifery - OB/GYN team. A minimum of 24 hours a week are spent in the clinical practicum as part of the above requirement. Two days a week are set apart for study and seminars.

FAMILY NURSING III

Nurse-Midwifery - Part II

The second half of the nurse-midwifery component prepares the student for certification as a nurse-midwife. Prerequisite for this trimester is successful completion of FN-IA and FN-II.

The FN-III trimester focuses on care and management of the woman during labor and delivery and the high risk neonate. FN-III modules are:

Intrapartum Module

Theory and clinical practice in the care and management of normal labor and delivery, learning to anticipate and recognize complications and to manage them in collaboration with other members of the OB/GYN team. Clinical experience takes place at FNS and affiliated agencies. Nine credit hours.

High Risk Neonate Module

Theory and clinical practice in the care and management of the high risk infant. Knowledge and skills are built on the mastery of objectives in the normal neonatal module. Three credit hours.

Nurse-Midwifery Clinical Practicum II

For the clinical experience described in the above modules, students are assigned to the nurse-midwifery - OB/GYN team. A minimum of 24 hours a week are spent in clinical practicum as part of the above requirement. Two days a week are set aside for study and seminars.

ADMISSIONS CRITERIA

An applicant must be a graduate of an approved school of nursing (associate degree, diploma, baccalaureate or masters program), and must be licensed in Kentucky. The applicant must present satisfactory professional references and transcripts, and be in good health. An applicant must have a minimum of one year of postgraduate nursing experience, preferably as a general staff nurse. If interested, program applicants may apply to the FNS for a staff position at the Mary Breckinridge Hospital.

Applicants will be required to spend a period of one month with the FNS for orientation prior to admission. During this month, the FNS will provide the applicant's room in FNS housing. The orientation period will serve to acquaint the applicant with the system and help her adjust to the culture and the role of a primary care nurse. The applicant may withdraw during this period, or may be counseled to withdraw by faculty. However, if the applicant decides to accept admission, she may do so.

Applicants will be required to commit themselves for a minimum of one year post-education employment on the staff of the FNS, provided vacancies are available, upon satisfactory completion of the educational program, unless sponsored by another agency.

Preference for admission will be given to candidates:

who come from other Kentucky agencies and plan to return to their sponsoring agency;

who plan to work in rural areas of Kentucky, Appalachia, or in other medically understaffed areas of this country.

Limited space in each class is reserved for candidates recommended by the Tennessee State Department of Health.

One place in each class is reserved for candidates on furlough from an overseas assignment.

Applicants who have been graduated from a basic nursing program for more than two years should provide evidence of continuing education.

Applicants should have a driver's license.

APPLICATION PROCEDURE

Applications should be submitted at least one year in advance of the proposed admission date.

Applications are to be accompanied by a $50.00 application fee, the check or money order to be made payable to the Frontier Nursing Service, Inc.

Transcripts of previous professional education must be submitted.

A request for a FNS scholarship, if desired, should accompany the application.

A statement of intent to accept one year of post-education employment on the staff of the FNS upon completion of the educational program must be included in the application. In the case of students sponsored from the State of Tennessee, from Kentucky agencies or from the foreign field, a letter of intent to employ from the sponsoring agency must be submitted.

An applicant will be asked, on the application, to comment on any significant health problems and to certify that her/his health is sufficiently good to enable her/him to do work described in the brochure. Applicants should note that annual physical examinations are required of FNS staff and Frontier School of Midwifery and Family Nursing students. The student will be scheduled for a physical upon arrival. If the student prefers, they may have the required physical done by a physician of choice a minimum of two months prior to coming to the FNS, and the record must be submitted to the School for the student's record.

Reference from previous employers will be obtained and the respondant will be asked to comment on the applicant in the following areas:

1) Reliability, thoroughness, efficiency and analytic sense in the performance of nursing functions;

2) Self-direction and constructive participation in staff and program development;

3) Relationship with patients, peers, ancillary staff, supervisors and physicians;

4) Suitability for work in a rural, economically deprived area which is conservative in outlook;

5) Suitability to undertake an educational program that is rigorous, demanding and service-oriented.

Upon receipt of all application material, the applicant will be scheduled for a two or three day interview at the FNS, at the applicant's expense.

Acceptance to the Frontier School of Midwifery and Family Nursing will be confirmed approximately six months prior to the beginning of the class.

FINANCIAL ARRANGEMENTS[3]

During the one-month orientation period, the prospective student receives room in the FNS housing.

School Fees

Application: The School application fee is $50.00. The application fee is not refundable if the applicant withdraws the application or is not accepted for admission. At the time the prospective student completes the School application, she/he will be asked to supply transcripts of previous education.

Tuition: $300.00 for each trimester, payable at the beginning of the trimester. Tuition is not refundable except under extenuating circumstances.

Room and Board: Students who live in FNS housing pay rent for their rooms, and buy their meals in the Mary Breckinridge Hospital cafeteria at an estimated cost of $3.00 per day. A central kitchen in the two main housing units at Hyden is available for students who wish to buy food and prepare their own meals. Room rent varies, depending upon the accommodation; $40.00 to $75.00 a month at the present time and students may not always have a choice of room upon arrival. However, it is the more permanent staff who usually choose to live in the higher cost accommodations and staff and students are allowed to move, either to a higher or lower cost room, as space becomes available. Students who do not choose to live in FNS housing may buy meals in the hospital cafeteria. Students who choose to live out of FNS housing must live within reasonable distance of the hospital and have a telephone.

Field Fees: A $50.00 field fee is charged at the beginning of each trimester to cover library, audiovisual aides and other educational expenses.

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[3] All fees subject to change without notice.

Other Expenses

Students are responsible for their own health insurance and are responsible for any medical costs incurred as an inpatient or outpatient which are not covered by insurance. When a student is seen by a FNS physician or consultant at the Mary Breckinridge Hospital, a professional discount is allowed. Students may purchase drugs at cost from the FNS pharmacy. If a student has to go elsewhere for consultation or admission, the cost must be met by the student.

Students are responsible for any textbooks they may wish to purchase. The textbooks used in the FSM and FN are available in the School library and expenditures for books depend upon the individual student. It is estimated that students spend from $40.00 to $150.00 on textbooks.

It is recommended that students bring with them an inexpensive cassette tape recorder since teaching tapes are available in the library for independent study.

The FNS offers students the opportunity to rent or purchase a diagnostic kit containing the following equipment; Littman Stethoscope, Tycos Blood Pressure Apparatus, Welch-Allen Otoscope-Ophthalmoscope with case, Tuning Fork, Neuro Hammer, Tape Measure, Penlight, Thermometer Case, Carrying Case. These kits may be rented for $25.00 with student responsible for breakage or loss of any of the equipment. The kits and their contents are purchased in quantity so the equipment can be made available to students who wish to buy them at a reduced cost. The price will necessarily vary somewhat. The last kits purchased cost FNS $228.00. The only optional piece of equipment is the stethoscope; otherwise, the kit must be purchased or rented in its entirety.

The FNS carries liability insurance which includes coverage of the students.

FINANCIAL AID

Scholarships are available from the FNS. The scholarship includes tuition, room rent and a monthly allowance of $90.00 toward the purchase of food. Scholarship recipients who live outside of FNS housing receive a monthly allowance of $130.00 ($40.00 for room rent and $90.00 for food).

Students applying for a scholarship have the following service obligation for:

1 trimester agree to spend 6 months on the FNS staff following graduation
2 trimesters agree to spend 9 months on the FNS staff
3 trimesters agree to spend 12 months on the FNS staff
4 trimesters agree to spend 16 months on the FNS staff

An FNS scholarship does not cover the field fee, health insurance or any other incidental expenses.

The scholarship may be paid back either in time or in money, after completion of the one year commitment.

The placement of a student on staff to fill the postgraduate or scholarship commitment will be decided according to the individual's choice when possible, but will depend on the positions available at the time and may include assignment to an agency with whom the Frontier Nursing Service has a contract for service.

UNIFORMS

Students are responsible for their own uniforms. Students assigned to the hospital inpatient floor wear conventional white uniforms or pant suits. In the outpatient clinic students may wear a white uniform or appropriate street clothes with a full length lab coat. No jeans or full length skirts are allowed. A name pin will be supplied.

Students assigned to district will be expected to wear blue skirts or slacks with a white blouse and blue vest.

FACILITIES

Students in the Frontier School of Midwifery and Family Nursing may live in quarters near the Mary Breckinridge Hospital which are provided by the Frontier Nursing Service for its staff. Each student has a completely furnished single room. Haggin Quarters and Mardi Cottage have living rooms with television available and there is a recreation room in the remodelled Barn which also contains bedrooms and small apartments.

The classroom and teaching clinic for family nurse and nurse-midwifery students are located in the Mary Breckinridge Hospital where the students gain clinical experience in the outpatient clinics and on the inpatient wards. The Mary Breckinridge Hospital is a completely modern, forty-bed facility which was opened in February 1975. A reference library and audiovisual aids are available to the students. Students may also be assigned for clinical experience at district nursing clinics and in the homes of the patients.

VACATION AND SICK LEAVE

Students are allowed one week's vacation during each trimester. Vacation time is arranged by the faculty.

A student is allowed four days sick leave per trimester, either in one illness or in several shorter ones, which is not accumulative from one trimester to another. Any sick time in excess of four days per trimester must be made up by the student at the end of the course.

An unexcused absence from classroom studies or clinical experiences will result in an interview and a warning; the second unexcused absence will result in probation; the third unexcused absence will result in permanent dismissal.

EVALUATION AND STANDARDS

After admission to the Frontier School of Midwifery and Family Nursing, students:

1) Are expected to maintain high quality of work in the program. Students who do not meet expected clinical or academic standards will be notified and, if necessary, put on probation at the joint recommendation of faculty. Such students will be dealt with according to individual needs, and may be asked to withdraw if unable to meet expected standards.

2) Will be assessed at mid-term and following completion of each trimester to determine the suitability for continuing in the program. Evaluation is based on performance throughout the trimester and on written final examinations.

3) Will be required to complete each trimester in a satisfactory manner, demonstrate their competencies to perform the procedure taught, and assume concomitant responsibilities in the clinical area, before they may proceed to the next trimester.

4) "C" is considered a passing grade. Students will be required to earn the grade of "A" or "B" in order to be eligible to continue into the next trimester. For example, students must have a "B" grade in FN-IA to proceed to FN-IB; with a "C" they cannot proceed.

5) Will be jointly evaluated by the faculty before they are recommended for the American College of Nurse-Midwives National Certification Examination, and/or the ANA National Certification Examinations in Family Nursing.

ACCREDITATION AND CERTIFICATION

Program Approval and Accreditation

1. The Nurse-Midwifery Program

   a. The Nurse-Midwifery Program offered by the FNS was approved by the American College of Nurse-Midwives, 1973.

   b. It has been granted reciprocity by the Central Midwives Board of Great Britain Part I Midwifery, permitting students to be certified for Part I Midwifery. Required standards of training and practice are maintained to assure international reciprocity.

2. The Family Nursing Program

   a. The application for accreditation of the Family Nursing Program has been submitted to the American Nurses Association National Accreditation Board for accreditation as a continuing education program.

Individual Certification

1. Nurse-Midwifery Certification

Nurse-midwifery national certification examinations, by the American College of Nurse-Midwives, are given at the end of Family Nursing III. Following the successful completion of the ACNM examination, the student is eligible for national certification as a nurse-midwife by the College (C.N.M.). Application for this examination must be made no later than thirty days before the examination.

For additional information write:

The American College of Nurse-Midwives
1000 Vermont Avenue, N.W.
Washington, D.C. 20005

2. Family Nurse Certification

National certification examinations are offered by the American Nurses Association upon completion of an organized program of study which meets the Guidelines for Short-Term Continuing Education Programs Preparing Adult and Family Nurse Practitioners, or its equivalent; and two years of practice as a registered nurse in family or adult health care immediately prior to application, up to one year of which may have been in an organized program of study in an institution of higher learning or in a continuing education program.

For additional information write:

Certification Unit
American Nurses' Association
2420 Pershing Road
Kansas City, Missouri 64108

FEE SCHEDULES (Subject to Revision)

Students are responsible for their own fees for National Certification.

1) For Nurse-Midwifery Examinations fee schedule is:

Examination Fee $150.00

2) For Family Nurse Certification Examination fee schedule is:

$ 50.00	ANA members
$ 75.00	Members of specialty nursing organizations specifically designated by the Congress for Nursing Practice.
$125.00	Nurses not holding membership in any nursing organization.

Administrative fee: An administrative fee will be retained on all applicants who withdraw before the examination, are found to be ineligible, or submit partial materials which are then not completed by the filing deadline -- $15.00 ANA Member
$45.00 Nonmember

Students are awarded FNS certification upon satisfactory completion of the education program.

SPECIAL PROGRAMS

Family Nursing Internship

The FNS is pleased to offer a four-month internship in rural primary health care to graduates from other Family Nursing programs, who will accept a commitment for an additional eight months employment on the staff of the FNS. The major emphasis of the program will be on district nursing, and it is designed to prepare the primary care nurse for rural health services.

During the internship, FNS will provide one half day a week of continuing education (an interdisciplinary seminar focusing on case material). The remainder of the time will be spent in the clinical area, in the outpatient department of the Mary Breckinridge Hospital or in one of the nursing districts, as a member of a primary health care team.

The FNS, on the basis of past experience, believes that a minimum of one year's experience is required to gain a comprehensive understanding of rural health care management, and preference will be given to internship applicants who are interested in spending eight to twelve months on district.

During the four-month internship, the student will receive a monthly stipend of $425.00 (nontaxable). Students who live in FNS housing at Hyden or Wendover pay approximately $130.00 a month for room rent and meals (see page 18). If the nurse is assigned to a district nursing center, she makes her own housekeeping arrangements, but pays no rent and FNS maintains the property and heats the center.

After satisfactory completion of the four-month internship, the family nurse will receive a salary ranging from $9,000.00 to $12,000.00 a year, depending on academic preparation, experience and on responsibility assumed. The charge for room and meals remains the same for staff as for the student.

Occasionally, when space is available, FNS will give consideration to the nurse who is interested in the four-month internship without the ensuing eight-month employment commitment. In such cases the tuition fee for the internship is $300.00, plus the $50.00 field fee, and living expenses as noted above.[4]

Applications must be accompanied by a $50.00 registration fee which is not refundable.

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[4] All fees subject to change without notice.

UNIVERSITY AFFILIATION

The University of Kentucky College of Nursing and the Frontier Nursing Service were awarded a joint grant from the Division of Nursing (USPHS, DHEW) to develop an affiliation for the family nurse and nurse-midwifery education programs. Students with baccalaureate degrees in nursing who wish to pursue a master's degree are encouraged to apply to the University of Kentucky College of Nursing for admission to the graduate program at the same time they apply to the Frontier Nursing Service. Application materials may be obtained from the University by writing to:

Office of Graduate Studies
College of Nursing
University of Kentucky
Lexington, Kentucky 40506

There is no fee charged at the time of application to the University of Kentucky Graduate School. Students should stipulate their plans to complete the FNS program prior to entry and set an advanced date for admission to UK.

Subject to meeting general requirements for admission to the Graduate School (including the Graduate Record Examination), as well as the requirements of the master of science program in nursing, and to being enrolled, students will be eligible to write UK challenge exams for graduate credit including nurse-midwifery courses. Approval must be given by the Director of Graduate Studies in Nursing as well as the Dean of the Graduate School in order to challenge courses at the graduate level.

It is anticipated that it will take one to two semesters of study on campus to meet the master's requirements (12-15 credits of courses not offered at the Frontier Nursing Service) and to complete challenge examinations. A minimum of 34 semester hours of credit must be successfully completed for the MSN degree.

The University of Kentucky College of Nursing anticipates being ready to offer Family Nursing at the master's level by September 1977. It is anticipated that the Frontier Nursing Services students enrolled at the University of Kentucky would be eligible to challenge these courses in 1978. Nurse-midwifery students may currently apply for challenge examinations subject to being enrolled as UK students.

In 1978, the College of Nursing will implement the new upper division, articulated baccalaureate curriculum, at which time R.N. students who meet admission requirements will be enrolled at the junior level. A family nursing component will be incorporated in the new curriculum which will not include all of the components to be offered in the family nurse program currently being developed at the master's level.

SCHEDULE FOR THE FAMILY NURSE/NURSE-MIDWIFE PROGRAM

1977

Winter Trimester.......................................January 31, 1977
Summer Trimester.......................................May 31, 1977
Fall Trimester...August 29, 1977

1978

Winter Trimester.......................................January 2, 1978
Summer Trimester.......................................May 1, 1978
Fall Trimester...August 28, 1978

FN-IA is offered in the Fall and Winter Trimesters only.

FN-IB is offered in the Winter and Summer Trimesters only.

FN-II is offered in the Summer and Fall Trimesters only starting Fall 1977.

FN-III is offered in the Fall and Winter Trimesters only starting Winter 1978.

Each trimester is four months in length with one week of vacation. Students who remain out of class for a trimester, will not be assured of a place in the class of the following trimester, unless there is an unexpected drop out.

Students who wish to take nurse-midwifery only, should plan to enroll in the program in the Winter trimester. Due to limited availability of clinical experience, the number of students accepted for nurse-midwifery only is restricted.

FOR APPLICATION FORMS FOR THE SCHOOL AND FURTHER INFORMATION, ADDRESS:

Registrar
Frontier School of Midwifery and Family Nursing
Frontier Nursing Service
Hyden, Kentucky 41749
Telephone: 606-672-2901

FOR APPLICATION FORMS FOR STAFF EMPLOYMENT AND INFORMATION, ADDRESS:

Associate Director and Director of Nursing
Frontier Nursing Service
Hyden, Kentucky 41749
Telephone: 606-672-2901

ADMINISTRATIVE STAFF AND FACULTY

Administrative Staff

W.B.R. Beasley, M.D., M.P.H., D.T.M.&H....................Director of FNS
(University of Kentucky Voluntary Faculty Appointment)

Evelyn Peck, R.N., M.A...........Associate Director & Director of Nursing

Elsie Maier, M.S.N., C.N.M., C.F.N.C.......Director of Frontier School of Midwifery and Family Nursing
(University of Kentucky Voluntary Faculty Appointment and Vanderbilt Faculty Appointment)

Alice Whitman..Registrar

Faculty

Carolyn Miller, M.A., C.N.M.........Nurse-Midwifery Education Coordinator

Christine Schenk, M.S.N., C.N.M., C.F.N.P........Family Nursing Education Coordinator

Anne A. Wasson, M.D., A.B.F.P...............Medical Education Coordinator

Brad Gascoigne, M.D. (Board Eligible)................Pediatric Instructor

Eva Fidelia Gilbert, M.D.................................OB/GYN Instructor

Karen Gordon, M.P.H...........................Health Education Instructor

Ida Laserson, M.S.N., C.N.M., F.N..............Nurse-Midwifery Instructor

Molly Lee, C.N.M., M.T.D.......................Nurse-Midwifery Instructor

Lillian Link, B.S.N., F.N..........................Family Nurse Instructor

Phillip Reppond, M.S.W..............................Social Work Instructor

Esther Seeley, R.N., M.N.........................Pediatric Nurse Instructor

Carol Tracy, B.S., P.N.P..............................Pediatric Instructor

Clinical Faculty

Susan Albritton, R.N., C.N.M., F.N...............Family Nurse-Midwifery

Gail Alexander, R.N., F.N.................................Family Nursing

Ruth Blevins, C.N.M., F.N.........................Family Nurse-Midwifery

David Coursin, M.D.......................................Family Medicine

Thomas Dean, M.D., A.B.F.P...............................Family Medicine

Christina Guy, R.N., F.N..................................Family Nursing

Susan Harris, R.N., G.N.M., F.N..................Family Nurse-Midwifery

Bernadette Hart, R.N., C.N.M.............................Nurse-Midwifery

Ronald Hart, M.E.....................Primary Care Management Instructor

Wanda King, R.N., G.N.M., F.N....................Family Nurse-Midwifery

Sharon Koser, B.S., F.N...................................Family Nursing

Joseph A. Levine, D.D.S..Dentistry

Joe Lewis, B.S., R.Ph...Pharmacy

Rita Miller, R.N., F.N....................................Family Nursing

Laura Pilotto, R.N., F.N..................................Family Nursing

Cynthia Sherwood, C.N.M., F.N....................Family Nurse-Midwifery

Mable Spell, C.N.M., F.N.........................Family Nurse-Midwifery

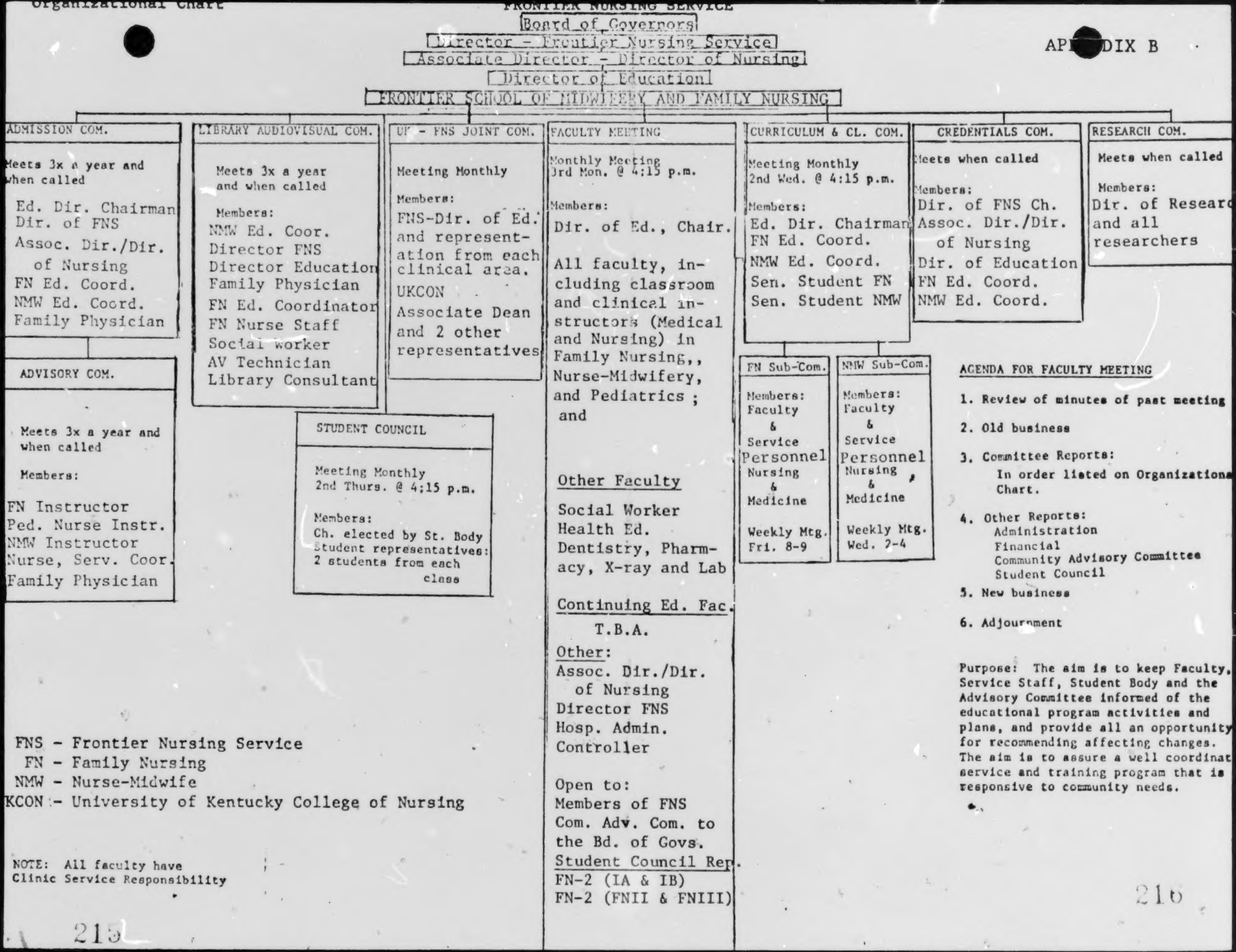
Stephen Thorngate, M.D., F.A.C.S..................................Surgery

Elizabeth Washak, M.S.N., C.N.P...........................Family Nursing

Elaine Waters, M.S.N., F.N.C..............................Family Nursing

Mary Weaver, R.N., C.N.M., F.N...................Family Nurse-Midwifery

APPENDIX B



FRONTIER NURSING SERVICE

Board of Governors

Director - Frontier Nursing Service

Associate Director - Director of Nursing

Director of Education

FRONTIER SCHOOL OF MIDWIFERY AND FAMILY NURSING

ADMISSION COM.

Meets 3x a year and when called

Ed. Dir. Chairman
Dir. of FNS
Assoc. Dir./Dir. of Nursing
FN Ed. Coord.
NMW Ed. Coord.
Family Physician

ADVISORY COM.

Meets 3x a year and when called

Members:

FN Instructor
Ped. Nurse Instr.
NMW Instructor
Nurse, Serv. Coor.
Family Physician

LIBRARY AUDIOVISUAL COM.

Meets 3x a year and when called

Members:

NMW Ed. Coor.
Director FNS
Director Education
Family Physician
FN Ed. Coordinator
FN Nurse Staff
Social worker
AV Technician
Library Consultant

UK - FNS JOINT COM.

Meeting Monthly

Members:

FNS-Dir. of Ed. and representation from each clinical area.

UKCON

Associate Dean and 2 other representatives

STUDENT COUNCIL

Meeting Monthly
2nd Thurs. @ 4;15 p.m.

Members:

Ch. elected by St. Body
Student representatives: 2 students from each class

FACULTY MEETING

Monthly Meeting
3rd Mon. @ 4:15 p.m.

Members:

Dir. of Ed., Chair.

All faculty, including classroom and clinical instructors (Medical and Nursing) in Family Nursing,, Nurse-Midwifery, and Pediatrics ; and

Other Faculty

Social Worker
Health Ed.
Dentistry, Pharmacy, X-ray and Lab

Continuing Ed. Fac.

T.B.A.

Other:

Assoc. Dir./Dir. of Nursing
Director FNS
Hosp. Admin.
Controller

Open to:
Members of FNS
Com. Adv. Com. to the Bd. of Govs.

Student Council Rep.

FN-2 (IA & IB)
FN-2 (FNII & FNIII)

CURRICULUM & CL. COM.

Meeting Monthly
2nd Wed. @ 4:15 p.m.

Members:

Ed. Dir. Chairman
FN Ed. Coord.
NMW Ed. Coord.
Sen. Student FN
Sen. Student NMW

FN Sub-Com.

Members:
Faculty & Service Personnel
Nursing & Medicine

Weekly Mtg.
Fri. 8-9

NMW Sub-Com.

Members:
Faculty & Service Personnel
Nursing & Medicine,

Weekly Mtg.
Wed. 2-4

CREDENTIALS COM.

Meets when called

Members:

Dir. of FNS Ch.
Assoc. Dir./Dir. of Nursing
Dir. of Education
FN Ed. Coord.
NMW Ed. Coord.

RESEARCH COM.

Meets when called

Members:

Dir. of Researc
and all researchers

AGENDA FOR FACULTY MEETING

1. Review of minutes of past meeting
2. Old business
3. Committee Reports:
   In order listed on Organizationa
   Chart.
4. Other Reports:
   Administration
   Financial
   Community Advisory Committee
   Student Council
5. New business
6. Adjournment

Purpose: The aim is to keep Faculty, Service Staff, Student Body and the Advisory Committee informed of the educational program activities and plans, and provide all an opportunity for recommending affecting changes. The aim is to assure a well coordinat service and training program that is responsive to community needs.

FNS - Frontier Nursing Service
FN - Family Nursing
NMW - Nurse-Midwife
KCON - University of Kentucky College of Nursing

NOTE: All faculty have Clinic Service Responsibility

FRONTIER SCHOOL OF MIDWIFERY
AND FAMILY NURSING

MANAGEMENT APPROACH

The nurse who functions as a clinician has extended her nursing role to include management of patients. Management in this context embodies problem solving as well as planning and implementing health care and promotion. This Management Approach is written to provide an organized, systematic process for developing management skills.

The service, school and students should have a clear idea of the goals in patient service and quality of care expected. An attempt has been made to identify measureable objectives in communication and problem solving skills. The purpose of specific objectives is to enable us to know that set goals are being achieved; by individuals, by the service and school. A clear guide to management should encourage consistency in service and education.

Specific clinical knowledge and skills will be handled in separate courses. The objectives in the Management Approach express overall expectations of students in their approach to any clinical situation.

FNS #49

MANAGEMENT APPROACH

To remain within the Family Nurse Program the student must consistently demonstrate to the satisfaction of self, the patient, the family, colleagues and instructors designated by the school:

1. A professional approach to patients and families characterized by respect and compassion, which is non-judgemental and unbiased.
2. Accountability for safe management of patients.
3. Utilization of the Management Approach of F.N.S., which includes adherence to the Medical Directives.
4. Effective use of communication skills in each step of management. Adequate documentation of management, in writing, in conformity with F.N.S. record requirements.
5. Identification of social and cultural factors affecting well being and incorporation of these in each phase of management.

MANAGEMENT APPROACH

	Steps in Management	Includes
INITIAL CONSULTATION WITH INSTRUCTOR OCCURS AT ANY LEVEL: A. Depends on student's level of mastery, as validated by written evaluations. B. Mutual clarification at beginning of clinical experience to be initiated by student.	1. Collects information about the patient's needs.	1. Reason for seeking medical care Chief complaint History: health, family, social Review of Chart Physical Exam, Diagnostic Tests
	2. Assesses needs.	2. A. Student's need for more information. B. Needs of patient. 1. Tentative diagnosis. 2. Diagnosis
	3. Formulates a plan with rationale, to meet needs.	3. Based on: (a) Theory (b) Experience (c) Medical Directives (d) Patient's desire Includes criteria to later evaluate effectiveness of plan.
	4. Consults instructor; M.D. (as necessary)	4. Confirmation of #1, 2, 3 Mutual re-evaluation Sharing of differing rationale
EPEATED CONSULTATION WITH NSTRUCTOR AS NEEDED: Student's needs. Instructor's request.	5. Modifies plan as necessary.	5. According to input from #4, 5
	6. Carries out plan.	6. Implementation
	7. Evaluates management	7. Evaluate: (a) Effectiveness of care. (b) Own action in process of management. (c) Adequacy of learning resources

Initial Consultation:

1. Initiates consultation with instructor or supervisor at appropriate time according to:
    a. Urgency of patient's condition.
    b. Level of nurses knowledge and skill.

2. Communicates clearly consultation needs and urgency to instructor or MD.

I. Collects Information

1. Creates an atmosphere of acceptance, concern, trust and freedom of expression by non-verbal and verbal communication.

2. Calls patient/family by name and introduces self.

3. Explains what she will do and purpose.

4. Provides for privacy.

5. Obtains a complete and accurate history utilizing effective communication skills.

    a. Uses support, reassurance and empathy during interview.
    b. Establishes purpose of interview with patient/family.
    c. Adapts vocabulary to patient's understanding.
    d. Asks open-ended questions when appropriate.
    e. Avoids "giving patient answers".
    f. Listens attentively.
    g. Responds to fears and anxiety of patient which may interfere with ability to supply information.
    h. Allows patient to complet thought before asking questions.
    i. Validates assumptions made by checking with patient.

6. Identifies patient response, verbal and non-verbal (mood, attitude affect, mental status).

7. Describes significant finding: history, physical, lab. exam) systematically, concisely, accurately,
    a. in writing on appropriate forms.
    b. orally to instructor/M.D.

II. Assesses Needs

1. Identifies needs and resources of patient/family.

2. Identifies own need for more information.
    a. Theory base
    b. From patient/family

3. Interprets findings and identification of needs as appropriate to patient and family.

4. Validates findings and identification of needs with patient, family. Records same before consultation.

5. Develops criteria for evaluation of a plan to meet identified needs.

III. Formulates A Plan

1. Explores with patient/family how we can help meet identified needs.
   a. What have they done in past?
   b. What are the alternatives.
   c. What other professional opinions have they had?

2. Consults Medical Directives and other resource materials as indicated.

3. Formulates a plan of Management with supporting rationale. (Scientific basis, available resources, patient/family desires)

IV. Consults

1. Reports findings, identification of needs to instructor, M.D. if necessary.

2. Proposes plan of management with supporting rationale to instructor/M.D./patient/family.

V. Modifies

1. Modifies plan as necessary based on input from instructor/M.D./patient/family.

VI. Implementation

1. Explains and discusses plan of management with patient/family.

2. Reports patient's condition and needs to colleagues sharing care of patient.

3. Explains plan of management to colleagues.

4. Invites questions and clarifies plan with patient, family and colleagues.

5. Carries out plan (nursing care, medications, examinations, counseling, and teaching) as applicable.

6. Writes orders, instructions as applicable. Where helpful write out problems and management for the patient.

7. Conducts group discussion, class or demonstration as applicable.

VII. Evaluates Plan

1. Assumes responsibility for own learning through evaluation of management, and patient response.
2. Determines appropriate method to evaluate effectiveness of plan according to criteria developed.
3. Arranges appropriate follow-up for evaluation.
4. Communicates plan for follow-up
   a. in writing on appropriate form.
   b. verbally to person responsible for service.
5. Uses criteria established in # II. 5 to evaluate management.
6. Shares experiences with classmates/colleagues through seminars, case presentations, reports and discussions.

MANAGEMENT EVALUATION

General Management and Communication Skills

	COMMENTS		
Objectives	F.N. I	F.N. II	F.N. III
MANAGEMENT APPROACH			
Demonstrates:			
1. A professional approach to patients and families characterized by respect and compassion, which is non-judgemental and unbiased.			
2. Accountability for safe management of patients.			
3. Utilizations of Management Approach of F.N.S., which includes adherence to the Medical Directives.			
4. Effective use of communication skills in each step of management. Adequate documentation of management, in writing, in conformity with F.N.S. record requirements.			
5. Identification of social and cultural factors affecting well-being and incorporation of these in each phase of management.			
Initial Consultation:			
1. Initiates consultation with instructor or supervisor at appropriate time according to: a. Urgency of patient's condition. b. Level of nurses; knowledge and skill.			
2. Communicates clearly consultation needs and urgency to instructor or M.D.			
I. Collects Information			
1. Creates an atmosphere of acceptance, concern, trust and freedom of expression by non-verbal communication.			
2. Calls patient/ family by name and introduces self.			
3. Explains what she will do and purpose.			
4. Provides for privacy.			
5. Obtains a complete and accurate history utilizing effective communication skills.			

MANAGEMENT EVALUATION

General Management and Communications Skills

	COMMENTS		
Objectives	F.N. I	F.N. II	F.N. III
a. Uses support, reassurance and empathy during interview.			
b. Establishes purpose of interview with patient/family.			
c. Adapts vocabulary to patient's understanding.			
d. Asks open-ended questions when appropraite.			
e. Avoids "giving patient answers".			
f. Listens attentively.			
g. Responds to fears and anxiety of patient which may interfere with ability to supply information.			
h. Allows patient to complete thought before asking questions.			
i. Validates assumptions made by checking with patient.			
6. Identifies patient response, verbal and non-verbal (mood, attitude affect, mental status).			
7. Describes significant finding: history, physical, lab. exam) systematically, concisely, accurately,			
a. in writing on appropriate forms.			
b. orally to instructor/M.D.			
II. Assesses Needs			
1. Identifies needs and resources of patient/family.			
2. Identifies own need for more information.			
a. Theory base.			
b. From patient/family.			
3. Interprets findings and identification of needs as appropriate to patient and family.			
4. Validates findings and identification of needs with patient, family. Records same before consultation.			
5. Develops criteria for evaluation of a plan to meet identified needs.			

MANAGEMENT EVALUATION

General Management and Communications Skills

Objectives	COMMENTS F.N. I	F.N. II	F.N. III
III. Formulates A Plan			
1. Explores with patient/family how we can help meet identified needs. a. What have they done in past? b. What are the alternatives? c. What other professional opinions have they had?			
2. Consults Medical Directives and other resource materials as indicated.			
3. Formulates a plan of Management with supporting rationale. (Scientific basis, available resources, patient/family desires)			
IV. Consults			
1. Reports findings, identification of needs to instructor/M.D. if necessary.			
2. Proposes plan of management with supporting rationale to instructor/M.D./patient/family.			
V. Modifies			
1. Modifies plan as necessary based on input from instructor/M.D./patient/family.			
VI. Implementation			
1. Explains and discusses plan of management with patient/family.			
2. Reports patient's condition and needs to colleagues sharing care of patient.			
3. Explains plan of management to colleagues.			
4. Invites questions and clarifies plan with patient/family and colleagues.			
5. Carries out plan (nursing care, medications, examinations, counseling, and teaching) as applicable.			

MANAGEMENT EVALUATION

eneral Management and Communication Skills

	COMMENTS		
Subobjectives	F.N. I	F.N. II	F.N. III
6. Writes orders, instructions as applicable. Where helpful write out problems and management for the patient.			
7. Conducts group discussion, class or demonstration as applicable.			
VII. Evaluates Plan			
1. Assumes responsibility for own learning through evaluation of management and patient response.			
2. Determines appropriate method to evaluate effectiveness of plan according to criteria developed.			
3. Arranges appropriate follow-up for evaluation.			
4. Communicates plan for follow-up a. in writing on appropriate form. b. verbally to person responsible for service.			
5. Uses criteria established in # II. 5 to evaluate management.			
6. Shares experiences with classmates/colleagues through seminars, case presentations, reports and discussions.			

APPENDIX D

A PROPOSED MECHANISM FOR THE TEAM APPROACH AT FRONTIER NURSING SERVICE

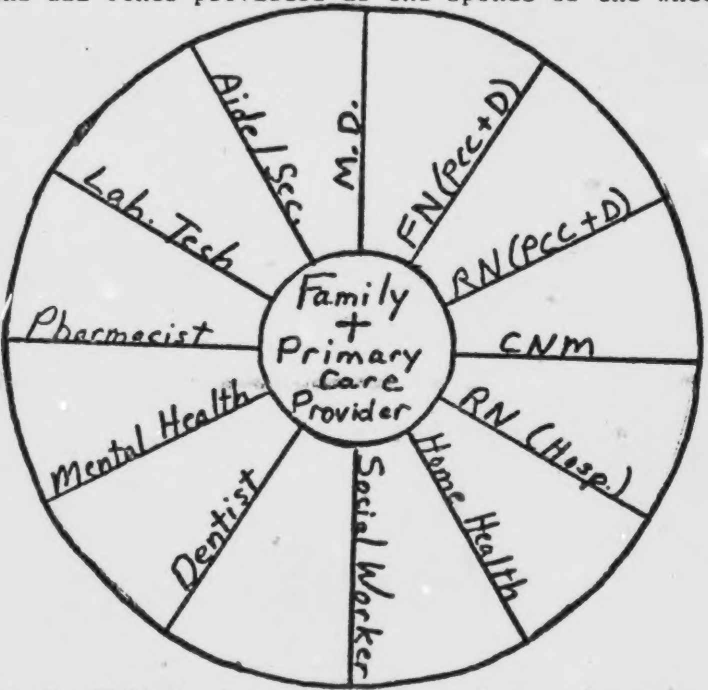
Prepared by

Elsie Maier, R.N., F.N.C., C.N.M.

A PROPOSED MECHANISM FOR THE TEAM APPROACH AT FRONTIER NURSING SERVICE

I. Definition of TEAM:

The TEAM approach to the delivery of health care to families provides continuity of patient services and insures better communication among all disciplines involved in providing that care. Family health care may be pictured as a wheel with the family and primary care provider as the hub and all other providers as the spokes of the wheel.

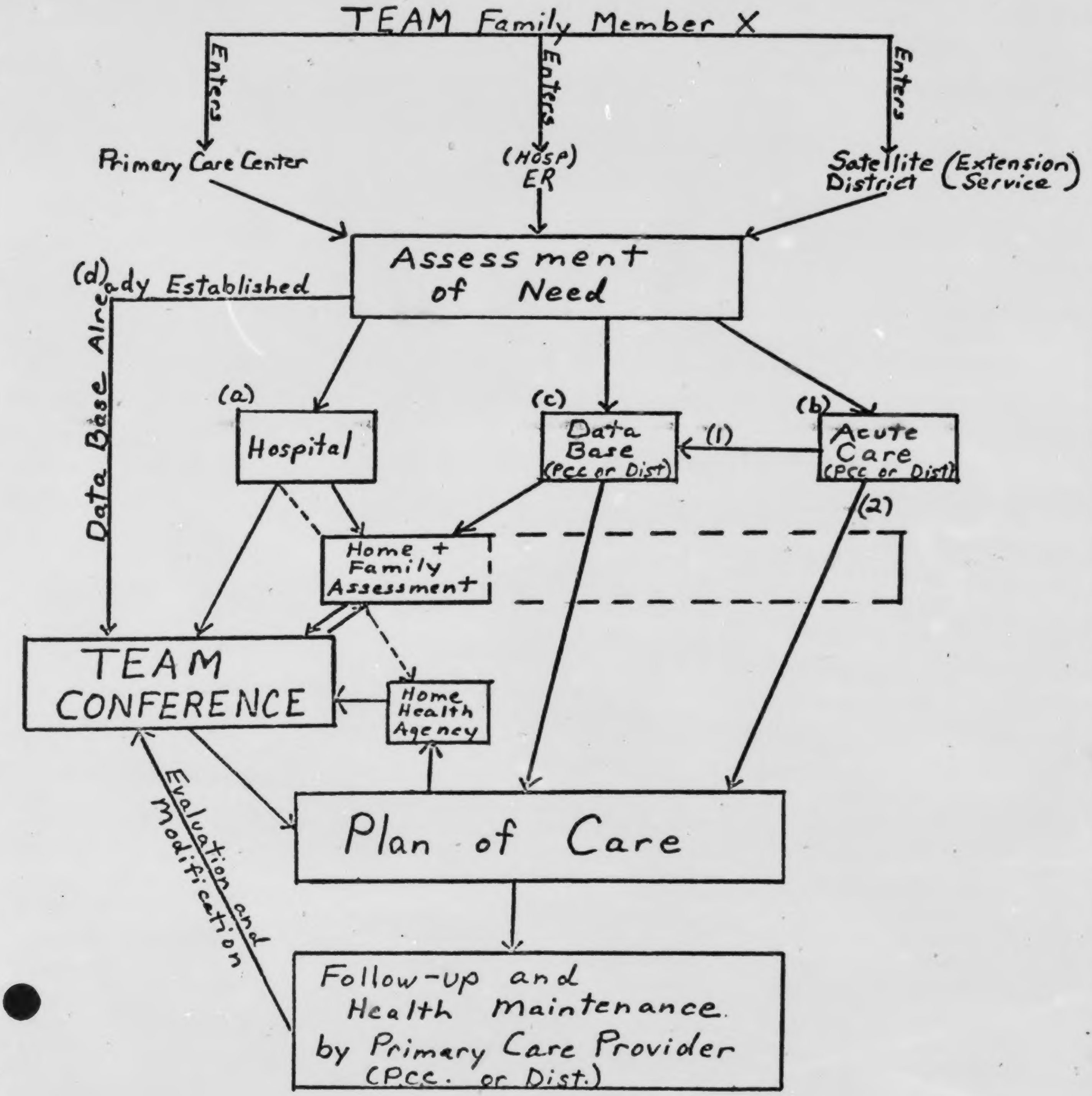

Family + Primary Care Provider
Aide/Sec.
M.D.
FN(pcc+D)
RN(pcc+D)
CNM
RN (Hosp.)
Home Health
Social Worker
Dentist
Mental Health
Pharmacist
Lab. Tech

One person on the TEAM is the primary care giver and may be any one of these participants. This person is responsible to coordinate the care for the family, develop a mutually agreeable plan of care, and provide information to the TEAM.

Each TEAM has its specific caseload of families, preferably within a designated geographic area. Ideally, a data base is gathered on each individual and family, and a plan of care is then developed which involves the participation of the family in the decision-making. Emphasis is placed on health maintanence and preventive care.

II. Sample Mechanism:

Patient care may be established in the following manner:


TEAM Family Member X
Enters
Enters
Enters
Primary Care Center
(HOSP) ER
Satellite District
(Extension Service)
Assessment of Need
(d) Data Base Already Established
(a)
Hospital
(c)
Data Base (PCC or Dist)
(1)
(b)
Acute Care (PCC or Dist)
(2)
Home + Family Assessment
TEAM CONFERENCE
Home Health Agency
Evaluation and Modification
Plan of Care
Follow-up and Health maintenance by Primary Care Provider (PCC. or Dist.)

Explanation:

The patient enters the health care system through the primary care center, the hospital emergency room or the satellite district (an extension of the primary care center). He may be seen and evaluated by any one of a number of providers. An assessment of his need is made and the patient may:

a) be directly hospitalized
b) have an acute problem diagnosed and treated
c) have a need for the establishment of a complete data base
d) already have a sufficient data base established

Then:

a) The patient who is hospitalized would be discussed at TEAM conference for the establishment of a coordinated plan of care. A home and family assessment may be done before or after the TEAM conference. The plan of care may include a referral to the Home Health Agency. In any case, the follow-up and health maintenance would be done by the primary care provider (either PCC or District), who would ask for help from the TEAM in the evaluation and modification of the plan of care if needed.

b) The patient with the acute problem would have their immediate needs met. Two options are then open:

1. In view of practicality, a plan of care can be developed with or without consult, with follow-up and health maintenance by the primary care provider. The data base can be collected over a period of time and the family can be discussed at TEAM conference as necessary. This facilitates care for those patients and families that are not complex. Various TEAM members may be consulted.
2. The more complicated patients should be scheduled for a complete history and physical (data base) with a home and family assessment. These patients may then have a plan of care established, most likely with review by the TEAM physician, and follow-up and health maintenance care would then be provided by the primary care giver. Various TEAM members may be consulted.

Problem individuals and families would be discussed at TEAM conference and a plan of care would be developed by the group. The plan of care may include a referral to the Home Health Agency or may be referred back to the primary care provider for implementation.

c) Patients who are assessed as needing the establishment of a complete data base would follow option #2 of (b). A home and family assessment would be done as deemed appropriate.

d) Patients who have a data base already established by previous care providers would be discussed at TEAM conference with an appropriate plan of care developed.

III. Proposal for Organization of TEAM at Frontier Nursing Service:

Since there are nine districts, it would seem feasible to have three TEAMS, consisting of a physician and three districts within each TEAM.

A. TEAM Members:

Each TEAM would consist of:

1) Family Physician
2) Primary Care Center:
   a. Family Nurses/CMN
   b. FN Student
   c. RN's
   d. Aides
   e. Secretary

3) Three Districts (Extension of PCC): (Selected according to geographic area and population served)

   a. Family Nurses/CNM
   b. FN Student
   c. RN
   d. LPN/Aide
   e. Secretary

4) Social Service

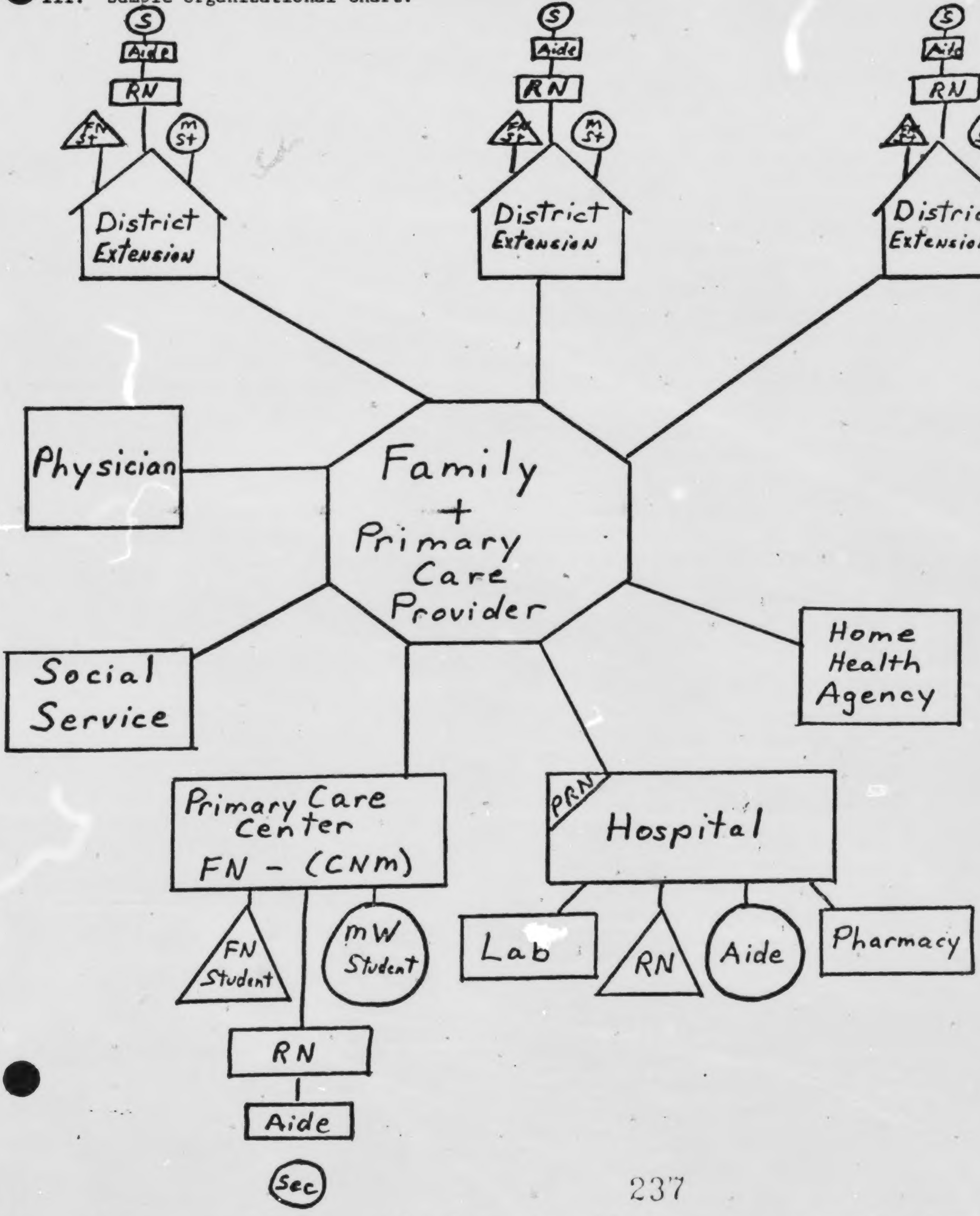
5) Home Health Agency:

   a. RN
   b. LPN/Aide

(PRN) 6) Hospital: These members are available as needed.

   a. RN on Med/Surg Floor
   b. Physician Specialists as needed:
      1) Surgeon
      2) Obstetrician
      3) Pediatrician
      4) Dentist
   c. Pharmacist (PRN)
   d. Lab Technician (PRN)
   e. Mental Health Worker (PRN)

III. Sample Organizational Chart:


S
Aide
RN
FN St
M St
District Extension
S
Aide
RN
FN St
M St
District Extension
S
Aide
RN
FN St
M St
District Extension
Physician
Family + Primary Care Provider
Social Service
Home Health Agency
Primary Care Center FN - (CNM)
FN Student
mW Student
RN
Aide
Sec
PRN
Hospital
Lab
RN
Aide
Pharmacy

B. Responsibilities:

1. The TEAM as a Whole:

The TEAM is responsible to give total family care including:

a) diagnostic, treatment and maintenance services for all age groups; referral for specialty care.
b) treatment of injuries and minor trauma
c) pre and postnatal care, family planning
d) preventive health services, (well child care, immunizations and health education)

At the FNS, family nurses are prepared in these areas and function under the direction of the physician, using Medical Directives. FN-II students (beginning midwifery) could participate as a TEAM member giving the pre and postnatal care and family planning. FN-III students would continue to deliver all prenatals under the supervision of the nurse-midwifery staff and the obstetrician. They would become part of the TEAM at such time as those patients present themselves for care.

All TEAM members attend TEAM conference once a week, participate in continuing education, and are on call as necessary.

2. Specific TEAM Members:

a) Physicians:	three districts, with visit to each once a week see own patients two afternoons a week medical care of team patients that are in hospital consult for FN and RN
b) FN—CNM:	total family care with own caseload supervise students and coordinate activities consult with M.D. when necessary does pre and postnatal, family planning and Health Assessments.
c) FNI Student:	in district and PCC - provide primary care under supervision of FN H&P's on caseload patients - keep data base up H&P's on admitted caseload patients home and in hospital visits and management involved in community health education, school visits WCC classroom instruction 2 days a week assist FN as she directs doing follow-up checks have own small caseload of patients

d) MW Student: classroom instruction as have now
all hospital deliveries
community instruction
two PM's a week work with FN—CNM for pre-natal and postnatal care.
see patients in MTD clinic as now

e) Med Student: assigned to a TEAM
responsibilities as directed by MD

f) RN: carry selected caseload under direction of FN/MD
assist in follow-up care according to plan

C. Communication:

1. TEAM conference: communication depends primarily on the regular and consistent attendance of all TEAM members on a weekly basis. "PRN members" attend according to the caseload being discussed.

The TEAM discusses:

a) Administrative problems - development of consistent introduction to TEAM for the public (verbal and written)

b) Identification of TEAM families

c) Development of individual and family plans of care for problem families.

d) Pooling of information/case discussions

e) Evaluation and modification of plans of care

2. PCC TEAM charts are marked with a flag identification. When the chart is completed by TEAM as well as Non-TEAM members, it is put in the specific TEAM physician's box for signing and screening. The physician then decides what needs to be reported to the rest of the TEAM at their meeting.

3. Linkage referrals outside the Primary Care Center - Getting information back from these consultants is a problem. Setting up a stable referral pattern with selected cooperative consultants will help. Perhaps a log could be kept of patients referred elsewhere and follow-up phone calls or letters may need to be done.

D. Episodic Care:

Episodic patients are assigned to TEAM according to the geographic area in which they live. The primary care giver explains for the TEAM functions and introduces its members.

If more than one TEAM's members are caring for that patient at that time, the involved persons meet and decide which TEAM is responsible and who is the primary care provider. On district, if the patient elects to continue to receive episodic care, he or she is still considered part of the caseload to the extent to which the patient wants to participate. In the primary care center, the patient would be seen by whoever is available at the time. The patient would be urged to consider the TEAM approach noting the advantage of knowing who his doctor and nurse is by name.

During the transition to the TEAM approach, TEAM members will help the primary care center with episodic care until their caseload developes to such an extent as time will not permit this. It is anticipated that the majority of patients will appreciate the TEAM approach to their care, thereby gradually decreasing the number of episodic patients needing to be seen.

E. Student Participation:

Family nurse students will be assigned to a TEAM and work under the supervision of the Family Nurse and the physician. They may be assigned to the primary care center, the district, the Emergency Room and episodic care. They will have classes two full days a week, leaving three full days for the clinical experience. This block of time will be particularly helpful to those assigned to district. An orientation, laboratory and pharmacy assignment will perhaps begin their experience.

Students will have the opportunity to do complete histories and physicals, in clinic and on in-patients. They will be able to follow families, do WC, home and family assessments and community education. They will see family health care provided in the true sense of the word. They will work with all age groups and a variety of acute and chronic problems. They will learn the essential component to success in health care delivery is communication at all levels.

It is hoped that nurse-midwifery students will be able to participate in the TEAM to round out the provision of health care to include intrapartal care.

IV. Phases of Development:

A. Develop TEAM concept:

Much thought research and work has gone into the development of the TEAM concept and how it can be adapted for use at the FNS.

B. Community Input and Education:

The Advisory Committee, district committees and local interested community groups have indicated a desire for a more consistent delivery of health care by the FNS. Individuals want to know who their doctor and nurse is and want them to stay long enough to provide continuity of care. With the TEAM approach, not only patient satisfaction will increase, but staff satisfaction will grow, hopefully to the point of long-term commitment to care.

More community input and education is desperately needed. In a poll of a randomly selected population in the Beech Fork district, the majority did not know what a family nurse does. Some said, "she takes care of the whole family" and "goes up the holler". No one mentioned that she can diagnose, treat, do health maintenance or preventive care.

C. TEAM Organization:

This proposal provides the mechanism as to how the system works. It is hoped that this phase of development may be initiated in the near future.

D. Community Introduction to TEAM:

This introduction will have to be done on a minimal scale until such time as the FNS is prepared to reorganize the complete primary care center and district system. It will then be necessary to educate and advertise to the public what services it has to offer.

E. Implementation:

Plans are being made to establish a trial TEAM starting June, 1976. This TEAM will serve as a model and will try to resolve some of the problems of implementation.

THE USE OF DRUGS AT THE FRONTIER NURSING SERVICE BY REGISTERED NURSES WITH SPECIALIST TRAINING IN FAMILY NURSING AND NURSE-MIDWIFERY

INTRODUCTION:

The Frontier Nursing Service has established a system of pre-printed prescriptions and pre-packaged medications in coordination with its Medical Directives which authorize the issuance of specific medications for a limited spectrum of diseases and health problems. These Directives and their related prescriptions are limited to the use of district nurses, family nurses, and nurse-midwives of the Frontier Nursing Service. The prescriptions are meticulously pre-coded to enable precise monitoring of the use of drugs within this health maintenance organization, which includes the Hyden Hospital and Health Center and nine nursing outposts in two counties.

In addition to providing the method to monitor this unique service program in Family Nursing and Nurse-Midwifery, it is felt that an additional use can be made of this data flow (1) to measure the effectiveness of the Medical Directives - Pre-Printed Prescription System, (2) to estimate the adequacy of the total Family Nurse training program in coping with health problems, and (3) to evaluate the competency of these specially trained nurses in the interdependent management of drugs.

BACKGROUND:

In preparation for expanding the training offered to registered nurses at the Frontier Nursing Service (FNS) in nurse-midwifery to include the diagnosis and management of common health problems, a careful analysis was made of the diseases and problems encountered by FNS district nurses in 25,000 outpatient contacts over a one-year period (1968-1969). Assuming this morbidity pattern to be a relatively stable one, and using a problem-oriented approach, a curriculum was designed to supplement pre-existing nursing knowledge and experience with an overlay of medical skills interwoven with advanced nursing techniques. The intent of the curriculum is to enable the specially trained family nurses and nurse-midwives to diagnose a limited spectrum of common health problems, to equip these nurses to provide adequate therapy for this limited disease spectrum, and, further, to orient these nurses for prompt and appropriate referrals of patients whose problems are outside the defined spectrum, and to handle emergencies they encounter according to directives until the physician becomes available. There is also a large preventive aspect in this curriculum.

Family nurses and nurse-midwives are taught to make a diagnosis on the basis of a complete history and physical examination with appropriate supportive laboratory studies. After establishing a working diagnosis, the family nurse is authorized to provide a limited amount of select medications for specific conditions. This authorization is provided through the published set of Medical Directives especially designed to direct the nurse in the usage of specific drugs for those common health problems identified in the morbidity study. Further, the nursing clinic is supplied with a set of pre-printed prescriptions, on each of which is listed the international codes of those diseases for which that medication is authorized. The disease codes on the prescriptions are grouped according to the level of training of the nurse who is to complete the prescription. Finally, the pre-packaged and pre-labeled medications are supplied.

Thus, when the nurse commits herself to a diagnosis, the coded number of the diagnosis and the directions for the medication are provided in the Medical Directives and repeated on the pre-printed prescription.

These pre-printed prescriptions may also be used for special patients not covered by the Medical Directives but for whom special orders are provided by the physician. Furthermore, in the case of emergencies when the situation requires that the nurse must take action and communication with the physician is impossible, the nurse may use the pre-printed prescriptions even though the condition for which she is using the medication is not coded on the prescription. Although the nurse does not sign the prescription, (this is the obligation of the monitoring physician who review these prescriptions on a weekly basis) she initials the prescription. The prescription is filled through the special pre-packaged arrangement of the Frontier Nursing Service Pharmacy, either at the outlying nursing clinics or at the centrally located Pharmacy at Hyden Hospital.

The use of these pre-printed prescriptions for selected coded diseases according to specific Medical Directives for specially trained nurses facilitate (1) the careful monitoring of the drugs being used under the authority of the Directives and by special orders of the physician, and (2) the identification of the inadequacies of the Medical Directives by providing specific data concerning the use of drugs in emergency situations on the initiative of the nurse without previous authorization.

Because the level of the training of each nurse using the prescriptions is identified, it is possible to compare the use of drugs by nurses with various levels of training. The age and sex of the patient provided on each prescription makes it possible to document the age-specific and sex-specific morbidity as perceived by various levels of nursing education, and to estimate the breadth of care that district nurse, family nurses, and nurse-midwives with varying levels of education can provide.

PROCEDURE:

This monitoring program and research project was implemented in the following manner: Each of the nine nursing clinics were provided with a set of Medical Directives, with a set of pre-printed prescriptions, and with pre-packaged prescriptions. When the family nurse or nurse-midwife makes a diagnosis, completes a prescription with a name, age, KMC number, and address of the patient, she encircles the coded medication on the prescription, indicating the authorization for medication, and she immediately provides the patient with the drug. The prescriptions are turned in on a weekly basis to the pharmacist. The pharmacist uses these prescriptions as an order to refill the supplies of the nursing clinic. Subsequently, the pharmacist and physician on the Pharmacy Committee validate each prescription, reviewing the diagnosis, the dosage for the age level, the adequacy of medication when more than one drug is indicated for the condition, the accuracy and completeness of each prescription, and investigate the use of those drugs issued on special medical orders and on an emergency basis. Problems identified are immediately discussed with the nurse over the telephone.

The system for the sue of drugs by family nurses and nurse-midwives in the FNS was designed by Archie M. Bennett, Jr., R.Ph., and was implemented in the summer of 1972. The pre-printed prescriptions and pre-printed labels are prepared in the FNS Pharmacy, using a Magnetic Card Selectric typewriter. The system has worked so efficiently in the monitoring of the use of drugs and also for cost accounting purposes that it was adapted last fall for use by central supply at Hyden Hospital which provides all nursing and medical supplies to the outpost nursing centers.

We feel that this system would be effective in any program using nurses in an expanded role.

Module # 1. History - Taking
2. General Survey
3. Head and Neck
4. Thorax and Lungs
5. Heart, Pressures and Pulses, Peripheral Vascular System
6. Breasts and Axillae
7. Abdomen
8. Female Genetalia
9. Male Genetalia
10. Anus and Rectum
11. Musculo-Skeletal System
12. Neurological System
13. Skin

FRONTIER SCHOOL OF MIDWIFERY AND FAMILY NURSING
FN IA

COURSE TITLE: Child Health Care

COURSE DESCRIPTION: A lecture/discussion course supported by clinical experience. The goal is to prepare the student to deliver primary and continuing care to children. Special emphasis will be placed on recognizing the individuality of each child, his membership within a family unit and the interrelationship of these two factors.

The content of this course is planned to emphasize the areas of Child Health Care essential to the nurse in her role as a Nurse-Practitioner.

COURSE OBJECTIVES: This course prepares students to:

1. Assess the child as a total person.
2. Recognize that the child has limited abilities to cope, participate, understand, reason, etc. without the support and guidance of adults.
3. Recognize that major developmental tasks are being achieved throughout life and appreciate that the foundation for the successful accomplishment of these tasks is laid in childhood.
4. Develop skill in the use of the tools of assessment for the purpose of evaluating the child's progress in physical, social, emotional and intellectual spheres of development.
5. Evaluate the family health as a necessary aspect of total health care, recognizing the interrelationship of the child and his family.
6. Initiate health care for other members of the family when deemed necessary.
7. Develop a continuing comprehensive plan of health care for the child according to the managment approach.

COURSE CONTENT:

1. Introduction to Child Health Care
2. Pediatric Procedures/Protocols
3. Pediatric Physical Assessment
4. Interviewing Parent and Child
5. Maternal-Child Relationships
6. Introduction to Growth and Development
7. Growth and Development: Newborn
8. Growth and Development: Infancy
9. Growth and Development: Toddler
10. Growth and Development: Preschool
11. Growth and Development: School Age
12. Growth and Development: Adolescence
13. Child Abuse

REFERENCE TEXTS: Alexander & Brown, Pediatric Physical Diagnosis for Nurses, New York, McGraw-Hill Book Company, 1974

FN-IA

COURSE TITLE: Principles of Human Physiology

COURSE DESCRIPTION: A basic course in human physiology including the functioning and regulation of the major body systems.

Offered by the University of Kentucky, Department of Physiology, at the Frontier Nursing Service. Four credit hours.

OBJECTIVES:

1. To learn the basic principles and mechanisms underlying physiological functions.
2. To learn the functions of the individual organs and organ systems.
3. To study the processes which regulate the organ systems and the interactions between these systems.

FRONTIER SCHOOL OF MIDWIFERY AND FAMILY NURSING
FN IA

COURSE TITLE: Family Nursing Seminar

COURSE DESCRIPTION: Concepts and methods of family assessment, health teaching, and clinical counseling in nursing are covered including case materials. Focus is on theory and techniques for assisting individuals and families to cope with developmental changes and related crises situations which are linked with health status. Selected field and observational experiences are included. Prerequisite: Consent of instructor.

COURSE OBJECTIVES: Upon completion of the course, students will be able to . . .

1. Describe the conceptual and empirical evolution of the role of the family nurse.

2. Compare selected family theories and their application to family health assessment.

3. Discuss fundamental concepts and methods of counseling and examine these in relation to the development of a personal approach.

4. Identify basic principles of learning and their application to methods of health education in family nursing.

5. Assess family and community health states and identify appropriate nursing interventions.

6. Identify methods of assisting families and individual members in coping with developmental changes and related crises.

COURSE OUTLINE:

1. Role and Philosophy of Family Nurse
2. Family Theories (the growing family, extended family, contracted family)
3. Family Health Assessment
4. Fundamental Concepts of Counseling
5. Approaches to Clinical Counseling in Family Nursing
6. Basic Principles of Learning in Relation to Health Teaching
7. Crises Intervention in Developmental Situations
8. Consultation and Evaluation in Family Nursing

INSTRUCTIONAL METHODS:

Lecture/Discussion/Seminar
Presentation of Case Materials
Group Projects/Presentations
Written Assignments
Selected Field and Observational Experiences

EVALUATION METHODS:	Group Projects/Presentations Written Assignments
REFERENCE TEXTS:	Hymovich, Debra P. and Barnard, Martha U.; Family Health Care; New York, New York; McGraw-Hill Book Company; 1973 Reinhardt, Adina M. and Quinn, Mildred D.; ed., Family-Centered Community Nursing; St. Louis, Mo.; The C.V. Mosby Company; 1973 Shertzer, Bruce and Stove, Shelley; Fundamentals of Counseling; Boston Mass; Houghton Mifflin Company; 1974

FN-IA
Clinical Practicum

COURSE TITLE: Family Nurse Clinical Practicum I

COURSE DESCRIPTION: The initial clinical practicum in family nursing is focused on a comprehensive appreach to health assessment of individuals and families throughout the age continuum. Using problem oriented recording, emphasis is placed on health maintenance and preventive care which includes counseling and teaching. Offered as part of FN-IA.

OBJECTIVES: Upon completion of the course, students will be able to:

1. Use health assessment techniques to identify normal from abnormal health states in individuals along the age continuum.
2. Identify health needs of family members using problem oriented recording.
3. Develop a plan of care which encompasses health maintenance and prevention.
4. Develop skills in utilizing consultants.
5. Implement individual and/or family care plans.
6. Evaluate individual and/or family care plans.
7. Assist families in assuming increased responsibility for their own health.

INSTRUCTIONAL METHODS: Clinical experience is selected settings.

Clinical conferences.

EVALUATION: Family/individual case presentations

Review of problem oriented records

Assessment of clinical practice

FRONTIER SCHOOL OF MIDWIFERY AND FAMILY NURSING
FN IB

COURSE TITLE: Identification and Management of Common Health Problems

COURSE DESCRIPTION: Focus is on the family nurse practitioners's identification and management of individual and family health problems (acute, chronic and emergency) commonly seen in a primary health care setting: Prerequisite: Consent of instructor.

OBJECTIVES: The student will:

1. Identify and explain the patho-physiology of disease with emphasis on signs and symptoms, clinical course, and treatment.

2. Utilize reference, texts, and journals in the current identification and management of specific health problems, thereby creating a pattern of study for continuing education.

3. Identify and explain principles of disease prevention and health promotion utilizing health related resources in the community.

4. Identify the problems of selected patients and develop a diagnostic, therapeutic, and educational plan of management.

5. Develop a practical approach to health care based on a scientific framework of knowledge and skills and incorporating the are of the professions.

6. Develop clinical judgement in determining appropriate management of problems (e.g., use of protocols jointly developed by medicine and nursing, consultation, referral, etc.).

7. Identify the rationale of using specific drugs, (i.e. drugs approved in FNS Medical Directives), including their pharmacological, therapeutic and toxicologic effects in managing common health problems.

8. Discuss and contrast the role of the nurse as a member of the health care team providing quality primary care in rural and urban settings.

METHODS OF TEACHING:

Lecture - Seminar
Case presentation
Guest lecturers
Audio-visual aides

EVALUATION: Written tests
Class presentation of group projects

CONTENT:

1. General overview
2. Trauma - major and minor
3. EENT
4. Epidemiology
5. Dermatology
6. Respiratory Disease
7. Cardio-Vascular Disease
8. Hematology
9. Gastro-Intestinal Disease
10. Renal Disease
11. Genital-Urinary Disease (Gyn)
12. Infectious Disease
13. Disease of Bones and Joints
14. Neurologic Disease

FRONTIER SCHOOL OF MIDWIFERY AND FAMILY NURSING
FN IB

COURSE TITLE: Advanced Family Nursing Seminar

COURSE DESCRIPTION: Focus is on specific techniques of counseling and teaching needed to assist individuals/families in coping with illness and disability. A variety of health delivery systems, in which the family nurse practitioner can function, will be explored as well as current research related to primary care. Prerequisite: Graduate status in nursing and/or consent of instructor.

OBJECTIVES: The student will:

1. Examine the role and philosophy of the Family Nurse in counseling and teaching patients/families to cope with illness and disability.
2. Develop a personal and professional philosophy of practice as a family nurse.
3. Explore the family nurse's role within the framework of an interdisciplinary team in various health systems.
4. Discuss research related to the area of primary nursing care and identify current problems in need of study.
5. Discuss issues affecting health care delivery systems at local, state, national, and international levels.
6. Examine legal implications and accountability of the emerging primary care roles in nursing.

METHODS OF TEACHING:
Seminar/Discussion
Group Presentations
Written Assignments

EVALUATION:
Presentations/Participation
Written Assignments

CONTENT:

UNIT I:
1. Orientation to Role Change
2. Women & Authority within the Health Care System
3. Levels of Health Care Delivery Systems: Role of the Family Nurse Practitioner

UNIT II:
1. Situational Crisis Intervention
    a. Acute
    b. Chronic
    c. Disability
    d. Life Threatening

UNIT III:
1. Accountability and Legal Aspects

UNIT IV:
1. Trends and Issues

FRONTIER SCHOOL OF MIDWIFERY AND FAMILY NURSING
FN IB

COURSE TITLE: Family Nurse Clinical Practicum II

COURSE DESCRIPTION: Clinical practicum in the management of adult, child and family primary health care in a variety of settings. Under nursing and medical supervision, students will gain experience in assisting patients and families to cope with illness and disability. Taken concurrent with NUR 554. Prerequisite: NUR 554 (or concurrent; NUR 662;) and/or consent of instructor.

OBJECTIVES: The student will:

1. Gain expertise in obtaining and recording a complete and accurate health assessment.
2. Identify social and cultural factors affecting the well-being of individuals/families and incorporate these in the management of care.
3. Interpret findings, identify needs, and develop a plan of care with supporting rationale.
4. Initiate consultation with preceptor, physician, and other appropriate sources in assisting individuals and families to meet health and medical care needs
5. Discuss and plan management of care with individual/family.
6. Implement and evaluate plan of care.
7. Demonstrate communication skills, including written documentation of patient/family management.
8. Demonstrate accountability for safe management of patient/family care.

METHODS OF TEACHING: Clinical rotations
Clinical conferences

EVALUATION: Case presentations
Chart/record review
Clinical assessment of patient/family management

FAMILY NURSING II

COURSE DESCRIPTION:

Family Nursing II, using the modular approach, introduces the student to management of the pregnant woman and her infant as long as they remain within the parameters of normal. It emphasizes education of the mother so that she will be able to understand and cope with all aspects of her pregnancy. Special emphasis is placed on the maternal-infant relationship in the immediate postpartal period, realizing the importance of early bonding in the development of good mother-child relationships.

The student concentrates on normal neonatology in order that she may recognize the high risk and abnormal neonate. All methods of Family Planning are included in the curriculum covered, and there is sufficient clinical experience for each student to become proficient in the various methods.

Normal gynecological problems are covered in the Family Planning/Gyn Module and the student is further exposed to more sophisticated gynecology in both the module and clinical practicum so that she may help the patient understand her problems.

OBJECTIVES:

Major objectives of the Antepartum, Postpartum, Neonatal, Family Planning and Gyn Modules prepare the student to:

1. Manage the care of antepartum patients in accord with the Management Approach of the FNS, demonstrating progress toward independant management.
2. Recognize, report and record anticipated deviations from normal during the antepartum period.
3. Manage the neonate from birth to 6 weeks of age, promoting physical mental and emotional development and well being.
4. Manage the puerperium, faciliating health promotion, self-care and family cohesiveness.
5. Manage woman's health care needs related to fertility, the reporductive tract and reporductive function.

COURSE CONTENT:

1. Two weeks of intensive didactic instruction.
2. Two six week rotations of concentrated clinical practicum; one in antepartum clinic, and one on the postpartum ward and neonatal nursery.

3. Weekly seminars by C.N.M. and physician.
4. Study day for independent work on modules.
5. Weekly Family Planning and Gynecology Clinic.
6. Clinical supervision available for each patient encounter until student has been evaluated and passed on an individual basis as being competent.

REFERENCE TEXT: Please see individual modules. All reference texts for modules are available in the Mary Breckinridge Hospital Library.

EVALUATION:

1. Clinical Exam
2. Case Presentations
3. Written Exams
4. Weekly Evaluations

FAMILY NURSING II

Midwifery Part I
Antepartal Module

COURSE TITLE: Modular Approach to Antepartal Care and Management of the Pregnant Woman

COURSE DESCRIPTION: The primary focus of this module is to understand the normal aspects of pregnancy and to anticipate or recognize any deviation from normal. This module integrates both the practical and theoretical knowledge and skills necessary to manage the antepartal course of the pregnant woman as long as she remains normal. The secondary focus of the module is to alert the nurse practitioner to the high risk obstetrical patient and her special needs in relationship to the patient and the unborn fetus. Education of the patient is basic to this module to enable the patient to understand and cope with all aspects of her pregnancy.

OBJECTIVES: This course prepares the student to:

1. Manage the care of antepartum patients in accord with the Management Approach, demonstrating progress toward independent management.
2. Facilitate and utilize purposeful communication, both individual and group to effect optimal patient care.
3. Facilitate the development of healthy family relationships through a positive, satisfying, child-bearing experience.
4. Identify social, cultural factors and community health resources, which might affect pregnancy and modify management based on this identification.
5. Identify significant others and their relationship to the patient.
6. Involve significant others that come to Prenatal Clinic with the woman in her prenatal care and preparations for the future.
7. Discuss previous childbirth experience with the antepartal woman.
8. Discuss measures appropriate for the various minor discomforts of pregnancy and involves significant others in these measures when possible.
9. Inform the patient of the privileges of having another person to stay with her during labor.

10. Inform the patient of the opportunity for rooming-in and family visiting.

11. Allow, facilitate or initiate discussion of fears and doubts, anxieties with expectant parents.

12. Initiate and encourage plans to include appropriate others in different aspects of the child-bearing experience.

13. Identify social and cultural factors and community health resources which might effect pregnancy and modifies the management based on this identification.

14. Collect pertinent information about home environment for purposes of effective teaching.

15. Identify distance and means of transportation to patients home.

16. List community resources available with:

    Financial
    Dietary
    Marital
    Psychological → NEEDS
    Housing
    Child Care

17. Identify high risk factors and deviation from normal, and plan appropriate intervention/consultation/referral.

COURSE OUTLINE:

Antepartum Module - Part I

Knowledge:

1. Anatomy of the Pelvis
2. Clinical Pelvimetry
3. Fetal Skull
4. Maternal Fetal Relationships
5. Signs and Symptoms, Diagnosis and Dating of Pregnancy
6. Physiological Changes in Pregnancy
7. Maternal Nutrition
8. Psychological Changes

9. Placental Development & Functions
10. Minor Discomforts of Pregnancy
11. Pharmacology
12. Vital Statistics
13. Lab Studies
14. Pelvic Floor

Skills:

Abdominal Palpation of the Pregnant Uterus

1. Inspection
2. Palpation
3. Auscultation

Clinical Pelvimetry

Assessment of Uterine Growth

Leopold's Maneuvers

Fetal Heart Tones

Measurement of Fundal Height

Antepartum Module - Part II: Medical Problems and High Risk Factors:

1. Reports and records anticipated deviations from normal during the antepartum period.
2. Identifies deviations from normal during the antepartum period.

Instructional Methods:

1. Lectures
2. Seminars
3. Case Presentations
4. Antepartal Module
5. Varied Clinical Experiences

6. One to one student/instructor ratio
7. Two week Intensive Course

Evaluation Methods:

1. Clinical Exam
2. Module Exams
3. Daily Clinical Evaluations

FAMILY NURSING II

Midwifery Part I

COURSE TITLE: Neonatal Module

MODULE DESCRIPTION: The newborn is a helpless human being, dependent on others for the fulfullment of all his needs. The infant's physical, mental, emotional growth, and development is directly related to the relationship established with those who meet his needs, but the newborn baby can't communicate clearly with those important people. Herein lies the challenge for nurse-midwives, who care for babies and their families at this crucial time of establishing relationships and adapting to extra-uterine life. By example, encouragement, and anticipatory guidance, we can facilitate the infant-parent attachment so vital for his future.

Another challenge in management of the newborn is the early and continued assessment of infants. The effects of deficiencies in intra-uterine environment, body structure or physiology may be greatly minimized by early detection and intelligent management.

We think you will enjoy seeing new mothers get to know their babies and develop confidence in caring for them. You will have the experience of working with mothers, babies and their families in the hospital, outpatient clinics, and at home. Clinical experience is the most important part of this module, and we hope to help you to make each clinical experience a valuable one for your learning.

OBJECTIVES: To successfully complete this module, the student demonstrates consistently, to the instructor designated by the school, her ability to:

1. Manage the neonate from birth to 6 weeks of age, according to the F.N.S. Management Approach, promoting physical, mental, and emotional development and well-being. Demonstrates progress toward independent management.

2. Use communication skills effectively during each phase of management.

3. Identify significant others (e.g. parent(s), family, friends), their effect on the neonate, their needs and incorporate them in the management.

4. Identify social and cultural factors and community health resources which might affect the neonate, their potential effect on the neonate; and modify the management based on this identification.

COURSE OUTLINE:

Pre-requisites: IM Injection for Infants
Denver Developmental

Knowledges:

Anatomy and Physiology of Newborn
Embryology
Placental Development and Physiology
Adaption to Extrauterine Life-transitional Changes
Normal Lab Values up to 6 Weeks
Normal Growth and Development up to 6 Weeks
Management of the Normal Newborn From Birth to 6 Weeks
Management of Minor Problems of the Normal Newborn
Minor Variations in the Newborn
Newborn Nutrition
Newborn Temperature Control

Skills:

Care of NN in D.R.
  a) Apgar
  b) Resuscitation, Krieselman
  c) Eye Care

Admission to Nursery
Neonatal Exam and Gestational Age
  a) Initial
  b) Discharge

Daily Care, Nursery
Teaching:
  Bath - Individual
    Group
  Formula - Individual
    Group
  Characteristics of NN
Discharge from Nursery
  PKU
NN Home Visit

Care of High-Risk NN:
  Isolette Care, O_2 analyzer, LSC
  Premature Care
  Gavage Feeding
  Bili-lights
  Dextrostix
  Bilirubin

EVALUATION:

1. Clinical Exam (See copy of clinical evaluation)
2. Module Exam

Midwifery Part I

COURSE TITLE: Post Partum Module

COURSE DESCRIPTION:

This module introduces you to the care and management of the new mother. The postpartum period is a time of change, adjustment, perhaps crisis for new mothers and their families. Our challenge as nurse-midwives is to help mothers and families to negotiate a time of change in the best possible state of physical and emotional health. We hope in our contact with postpartum families, to facilitate their growth toward their own potential of well-being.

You will be seeing new mothers in the hospital ward, clinic and on home visits. This module offers an opportunity to try out and strengthen your interviewing and teaching skills. Home visits provide a chance to observe family dynamics and relationships. We hope you will take time to get to know some of the families you meet, to share with them in their reactions to the outcome of pregnancy.

OBJECTIVES:

To successfully complete this module the student demonstrates consistently to instructors designated by the school, her ability to:

1. Manage the puerperium, according to the F.N.S. Management Approach, facilitating health promotion, self-care and family cohesiveness.
2. Use communication skills effectively in postpartum management and teaching.
3. Identify significant others (family and friends) their effect on the mother, their needs; and modify management based on this identification.
4. Identify social and cultural factors and community health resources which might affect the postpartum family, their potential effect, and modify management based on this identification.

COURSE OUTLINE:

Pre-requisites:

F.N. I & Pelvic Exam

Knowledges:

Physiology of Puerperium

Postpartum Assessment

Postpartum Management

Family Relationships in Puerperium

Emotional Needs of Puerperium

Mother-Infant Attachment

Grief

Complication of Puerperium:

- Puerperal Hemorrhage
- Puerperal Sepsis
- Thrombo-embolic Disorders
- Postpartum Psychosis

Skills:

Postpartum Exam

Individual and Group Patient Teaching

FAMILY NURSING II

Midwifery Part I

COURSE TITLE: Family Planning - Gynecology Module

MODULE DESCRIPTION: This module is intended to help the nurse-practitioner gain the knowledge necessary to provide competent and comprehensive primary health care services to women with contraceptive and gynecological needs. Women have not received the health services they need because of reluctance to approach predominately male physicians with problems of a very personal nature. The female nurse-practitioner is the ideal member of the health care team to provide primary health care for woman.

Consumers see the nurse-practitioner as a qualified professional, associated with family centered health care and seek from her the understanding and concern of someone with whom she can identify.

Mastery of all the objectives in this module is not required. You should fulfill the objectives related to areas of nurse-practitioner management, as established by guidelines of the employing agency. (At FNS this includes: Family Planning, infections and functional menstrual disorders.) We suggest that you gain as much knowledge as possible in all the areas covered, in order to provide safe and intelligent counseling and referral services.

The module is designed for use in conjunction with classroom presentations. Clinical experience will provide case material and a focus for study. The references listed after each objective are not the only source of information or perhaps not the best. Starred readings indicate a particularly well stated reference, in the opinion of the author. References lested are not required; information needed can be obtained from other current basic texts.

OBJECTIVES: Upon completion of this module, including classroom presentations, seminars, independent study, and clinical experience the student will:

1. Demonstrate an understand of theory basic to the safe management of women's health care needs related to fertility, especially Family Planning, the reproductive tract, and reproductive function.
2. Demonstrate clinical proficiency in fitting diaphragms, inserting IUD's, teaching rhythm, withdrawal, and the cervical mucous method, and prescribing oral contraceptives.
3. Demonstrate appropriate patient education.

3. Demonstrate appropriate patient education.

REQUIRED TEXTS: None - All texts and journals necessary for this module are in the Mary Breckinridge Hospital Library.

EVALUATION:
1. Clinical Performance
2. Written Exam

FRONTIER SCHOOL OF MIDWIFERY AND FAMILY NURSING

Hyden, Kentucky

MODULES FOR ADULT HEALTH ASSESSMENT

These modules have been prepared jointly by Ms. Elsie Maier, R.N., C.N.M., F.N.C., Frontier school of Midwifery and Family Nursing, Hyden, Ky. and Ms. Marilyn Hayes, R.N., F.N.C., Vanderbilt University School of Nursing, Family Nurse Clinician Graduate Program, Nashville, Tennessee.

ACKNOWLEDGEMENT

In the preparation of this material, the faculties of Frontier School of Midwifery and Family Nursing and Vanderbilt University School of Nursing wish to credit, with deep appreciation, the information derived from the modules of the Nurse-Midwifery Education Program at the New Jersey Medical School, College of Medicine and Dentistry of New Jersey, Newark, New Jersey, from the text, A Guide To Physical Examination by Dr. Barbara Bates, and from the University of Rochester School of Nursing, Rochester, New York.

July, 1976

FRONTIER SCHOOL OF MIDWIFERY AND FAMILY NURSING
FN IA

COURSE TITLE: ADULT HEALTH ASSESSMENT

COURSE DESCRIPTION: A clinical course designed to assist the nurse in developing a comprehensive approach to health assessment of the adult. Opportunity will be provided to practice beginning skills in history taking and physical examination and to employ basic diagnostic procedures in the assessment and management of health care.

COURSE OBJECTIVES: This course prepares students to:

1. Obtain a comprehensive health history utilizing effective interviewing techniques.
2. Perform a thorough physical examination, using the techniques of inspection, palpation, percussion and ascultation.
3. Employ common laboratory tests and diagnostic procedures in the identification of patients' needs.
4. Use normal anatomy and physiology as a baseline for recognizing the abnormal.
5. Identify the problems of selected patients and in consultation with an instructor, develop a plan of management, incorporating health maintenance and preventive care.
6. Implement and evaluate plan of care with the patient/family.
7. Evaluate the interaction and influence of the individual in relation to his/her family.
8. Record all findings accurately, systematically and concisely.

REFERENCE TEXT: Bates, Barbara; A Guide to Physical Examination, Philadelphia, Pa;. J.P. Lippincott Company; 1974.

Enlow, Allen J. and Swisher, Scott N.; Interviewing and Patient Care, New York; Oxford University Press; 1972

COURSE CONTENT: Two 3 hour classroom sessions per week by nurse and physician instructors. Clinical assignments 24 hours per week including health assessment clinic, ward work-ups, OPD.

Semi-modular curriculum consisting of a system review using a physiological, psycho-social approach:

Module # 1. History - Taking
2. General Survey
3. Head and Neck
4. Thorax and Lungs
5. Heart, Pressures and Pulses, Peripheral Vascular System
6. Breasts and Axillae
7. Abdomen
8. Female Genetalia
9. Male Genetalia
10. Anus and Rectum
11. Musculo-Skeletal System
12. Neurological System
13. Skin

FN-IA
ADULT HEALTH ASSESSMENT

Physician Lectures

There will be a lecture by a physician (1½ hours per week) focusing mainly on the assessment of a symptom. After studying assessment from the systems point of view, this approach will tie together meaningful relationships between systems.

Selected topics will include:

1. Health Maintenance - Preventative Care
2. Headache
3. Dizziness and Syncope
4. Nausea and Vomiting
5. Dehydration and Hypovolemia (Fluid and Electrolyte Balance)
6. Fever (Immune System)
7. Chest Pain
8. Cough, Dyspnea
9. Cardiac Arrhythmia
10. Abdominal Pain
11. Assessment and Care of Minor Trauma (Suturing)
12. Assessment of Bones and Joints
13. X-ray Interpretation
14. Neurosis/Psychosis

LABORATORY SESSIONS

FN-IA October 1976

OBJECTIVES:

1. To orient students to the lab, its routine and procedures.
2. To instruct students on the collection and processing of specimens.
3. To acquaint students with the method and significance of certain specified lab tests, providing a time for demonstration and return demonstration.

Provided:

1. A lab manual for each student.
2. Conference Room with teaching materials and lab equipment for practice sessions.
3. One week rotation through M.B.H. Lab, with a supervised experience in selected lab procedures.

CLASSROOM SESSIONS:

1. General orientation on lab policies and procedures, (lab slips, color of tubes, requirements for tests).
2. The care and use of the microscope.
3. Urinalysis
    a. Collection of specimen
    b. Labstix
    c. Specific gravity
    d. Microscopic urinalysis
4. CBC
    a. Hb/Hct.
    b. Peripheral blood smears
    c. White blood count
    d. Discussion on Differential, Smears for Eosinophils
5. Wet preps.
6. GC Smears and Cultures

7. Gram Stains

8. Cultures

    a. Obraining specimen (culturette, urine, blood)
    b. Streaking Agar Plates
    c. Strept Screens

9. Pregnancy Tests

10. Stool Exam

    a. Occult blood
    b. Ova and parasites
    c. Culture

11. Dextrostix/Blood Sugar

    SMA-12
    Electrolytes

LABORATORY EXPERIENCE:

The student will be provided the opportunity to:

1. Draw blood.

2. Make peripheral smears

3. Practice using microscope

4. Gain experience in doing urinalysis, wet preps, Hematocrits, Hemoglobin

5. Practice other selected lab procedures as interest and time allows.

MODULE NUMBER 1: HISTORY TAKING

I. Sub-objectives:
The student will be able to:

1. Utilize interviewing skills.
2. Elicit a precise, comprehensive health history.
3. Effectively record a health history using the POMR.
4. Utilize the health history as a means of establishing a problem list according to the POMR method.

II. Presentation of Content:

1. Lecture - Discussion
    a. General Approach to Patient
    b. Interviewing Skills
    c. Problem Oriented Medical Record
2. Programmed instruction unit: "Taking a Patient's History", American Journal of Nursing.
3. Taped histories.
4. Written histories on each other.
5. Videotapes
    a. Weed, Lawrence, Problem Oriented Medical Record
    b. NCME. POMR, University of Kentucky, Lexington, Kentucky
6. Handouts
    a. "Problem Oriented Charting", Wendover Form #491
    b. "Charting Terms", Community Hospital Los Gatos - Saratoga, January 1971.
    c. Sample Adult Data Base

III. Content Study Guide:

1. Define the following POMR nomenclature
    a. data base
    b. problem list
    c. plan
    d. SOAP'ed progress notes
    e. flow chart
2. Read and complete Program Instructions: Taking a Patient's History.
3. Explain how to develop rapport.
4. Explain what is meant by "characteristics" of nurse-patient relationship.

MARY BRECKINRIDGE HOSPITAL

PROBLEM LIST

PROBLEM NUMBER	PERMANENT PROBLEMS	DATE OF ON-SET	DATE PROBLEM RECORDED	DATE PROBLEM INACTIVATED

DURHAM-HARLAN FORM 533

PROBLEM NUMBER	TEMPORARY PROBLEMS	DATE OF ON-SET	DATE PROBLEM RECORDED	DATE PROBLEM INACTIVATED

MEDICATION HISTORY

Date ______________________________

Medications used in the past (e.g. B.C.P., ASA, diuretics, etc.)

DATES TAKEN	DRUG	DOSE

CURRENT MEDICATIONS

DATE STARTED	DRUG	DOSE	DATE DISCONTINUED

IMMUNIZATIONS: (Dates of original series, boosters)

DPT, TD								
	1	2	3					
POLIO								
	1	2	3	4				
PPD	DATE RESULT							

FLU				

________________ RUBELLA

________________ OTHER

DURHAM - HARLAN, #1003

PAST MEDICAL HISTORY Date ____________________

I[illegible]MANT: ____________________

ALLERGIES: ____________________

____

____

PATIENT BILL OF RIGHTS GIVEN: ____________________ (date)

HEALTH PROBLEMS INCLUDING HOSPITALIZATIONS, ILLNESSES, OPERATIONS, ACCIDENTS (chronologically)

DATE	*PROBLEM*	*OUTCOME*

Psych. Prob.
Cancer
Diabetes
Heart Disease
Hypertension
Epilepsy
TB
Hepatitis
Ulcers
Anemia
Arthritis
V.D.
COPD
Congenital Defects

CHILDHOOD ILLNESSES: (Dates if possible)

_______ German Measles
_______ Rheumatic Fever
_______ Other

_______ Measles
_______ Mumps

_______ Scarlet Fever
_______ Whooping Cough

DURHAM - HARLAN, #1004

PATIENT PROFILE

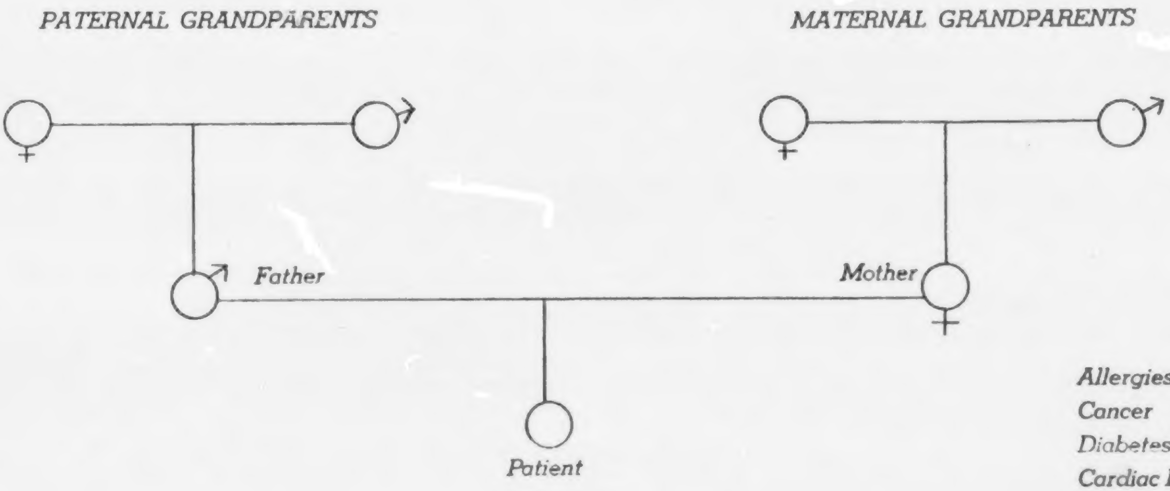
HABITS: DATE ____________________

Alcohol ____________________

Smoking ____________________

DAILY ACTIVITIES, FUNCTIONAL LIMITATIONS, HELPFUL FRIENDS OR FAMILY:

FAMILY HISTORY


PATERNAL GRANDPARENTS
MATERNAL GRANDPARENTS
Father
Mother
Patient

- *Allergies*
- *Cancer*
- *Diabetes*
- *Cardiac Disease*
- *Epilepsy*
- *Hypertension*
- *Hepatitis*
- *Thyroid Disease*
- *Tuberculosis*
- *Mental/Nervous Disorders*
- *Congenital/Familial Dis.*
- *Other*

♂ — *Male* ♀ — *Female* ● — *Expired*

Add great aunts & uncles and patient's spouse and children if significant health problem exist.

OB-GYN HISTORY

Date ____________ Menarche age ____________ Menses Interval ____________

Duration ____________ LMP ____________ Menopause Age ____________ Year ______

______ Irregular or frequent periods

______ Excessive flow or spotting

______ Painful periods

______ Dyspareunia

______ Vaginal discharge or itching

______ Date last Pap smear

______ Birth control. Type ______

PREVIOUS PREGNANCIES:

No.	Year	Weeks Gestation	Hours of Labor	Type of Delivery	Sex	WT.	Complications	Place of Delivery
1								
2								
3								
4								
5								
6								
7								
8								

DIETARY HISTORY:

Number of meals/day ____________ Favorite foods ____________

Adequacy of diet ____________

COMMENTS regarding significance of previously mentioned symptoms or symptoms not previously noted:

DURHAM - HARLAN, #1005

SYMPTOM LIST Date ______________________

Place a check (✓) in front of any of the following body parts or symptoms that are/or have been a problem. Double check (✓✓) the current problems. When more than one symptom is listed circle appropriate one.

SKIN

______ Rashes, color change
______ Itching, brusing
______ Warts, moles, lumps, hives
______ Excessive sweating
______ Gland swelling

HEENT

______ Head injury, concussion
______ Headaches
______ Dizziness, fainting
______ Ear trouble, infection
______ Hearing loss, noises
______ Vision loss, double vision
______ Glasses, difficulty reading
______ Nosebleeds
______ Sinus trouble, hay fever
______ Sorethroats, hoarseness
______ Dental problems
______ Goiter, thyroid problems

BREAST

______ Enlargement, painful breasts
______ Lumps, discharge from breasts

RESPIRATORY SYSTEM

______ Shortness of breath
______ Cough, chest colds
______ Bringing up sputum
______ Bringing up blood
______ Wheezing, asthma
______ Chest pain, pleurisy
______ Exposure to tuberculosis
______ Fevers, sweats, chills

CARDIOVASCULAR SYSTEM

______ Chest pain, tightness, pressure
______ Fast or irregular heart beat
______ Orthopnea
______ Waking short of breath
______ Swelling of feet or ankles
______ Previous heart trouble, murmurs
______ High blood pressure
______ Poor circulation, varicose veins
______ Blood clots

GENITOURINARY

______ Pain or burning on urination
______ Trouble starting or stopping urine
______ Discolored urine
______ Frequent urination
______ Sores or discharge

GASTROINTESTINAL

______ Food intolerance
______ Trouble swallowing
______ Poor appetite
______ Gas, cramps, pains
______ Heartburn, indigestion
______ Nausea, vomiting
______ Constipation, diarrhea
______ Blood in stool, hemorrhoids
______ Jaundice

MUSCULOSKELETAL

______ Pains in joints, arthritis
______ Back pain, neck pain
______ Swollen or red joints, stiffness

NERVOUS SYSTEM

______ Convulsions, fits, spells
______ Shaking, weakness, tremor
______ Numbness, tingling, paralysis
______ Difficulty walking, coordination
______ Depression
______ Poor sleeping
______ Nervousness, tension
______ Crying, upset, worrying
______ Sexual problems

Patient Data Sheet
FNS Form #291

Mary Breckinridge Hospital
Hyden, Kentucky

NAME: ____________________ MEDICAL RECORD # ____________________

RESPONSIBLE PARTY ____________________ RELATIONSHIP TO PATIENT: ____________________

STREET ADDRESS ____________________ S.S. # ____________________

CITY & STATE: ____________________ ZIP CODE: ____________ HOME PHONE # ____________

DATE OF BIRTH: ____________ SEX: ____________ MARITAL STATUS: M S D W ____________

HUSBAND (or wife's maiden name) ____________________ NUMBER OF CHILDREN: ________

FATHER'S NAME: ____________________ MAIDEN NAME OF MOTHER: ____________________

DISTRICT: ____________ COUNTY: ________ PLACE OF BIRTH: ____________

HOUSEHOLD MEMBERS	RELATIONSHIP TO PATIENT	SEX	D.O.B.	MED. REC. #	HEALTH PROBLEMS
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					

HOUSING ____________________

EDUCATION ____________________

OCCUPATION ____________________

RELIGION ____________________

MARY BRECKINRIDGE HOSPITAL

DIABETES FLOW SHEET

Date ____________________

Age at Diagnosis ____ Hx. Ketoacidosis (dates) ____________________

Special Problems ____________________

DATE	DIET	ADHERENCE	POLYURIA	POLYDIPSIA	HYPOGLY-CEMIA	OTHER SYMPTOMS	URINE TESTS		BLOOD SUGAR		WEIGHT	MEDICATIONS	RTC	COMMENTS
							am	pm	fasting	random				

SYMPTOMS: O None ++ Moderate

+ Mild +++ Severe

DIET ADHERENCE: G = good

F = fair

P = poor

N = Narrative Note

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5. Explain what is meant by the following interviewing techniques:

   a. open ended questions
   b. silence
   c. facilitation
   d. confrontation
   e. direct questioning
   f. support and reassurance

6. What is the specific content of the chief complaint and present illness.

IV. Content Practice Tasks:

1. Elicit, record and hand in a written health history from another person (taped history?).
2. Review a record, extract important data to be incorporated in past medical history, and write a problem list.
3. Practice presenting a patient history in a concise, organized manner.

V. Bibliography:

Common Office Terminology, Abbott Lab, North Chicago, Illinois

Enlow, Allen and Swisher, Scott. Interviewing and Patient Care, New York; Oxford University Press, 1972.

Neelon, Francis A. and Ellis, George J. A Syllabus of Problem-Oriented Patient Care, Boston; Little, Brown and Company, 1974.

Weed, Lawrence. Medical Records, Medical Education and Patient Care. Cleveland; Press of Case Western Reserve University, 1969.

MODULE NUMBER 2: GENERAL SURVEY

I. Sub-Objectives:

The student will be able to:

1. Observe the patient and recognize deviations from normal, noting apparent state of health, signs of distress; skin color; stature and habitees; posture, motor activity and gait; dress, grooming and personal hygiene; odors; facial expressions; manner, mood and relationships to surroundings, speech, state of awareness.
2. Measure and record accurately the pulse, respiratory rate, blood pressure and temperature, height and weight, noting deviations from normal.

II. Presentation of Content:

1. Lecture - Discussion
2. Demonstration of complete physical examination.
3. Handouts
    a. "Clinical Exam", F.N.S.
    b. F.N.S. Data Base Forms
    * c. Normals, F.N.S.

III. Content Study Guide - review and complete

1. Name a condition which could account for each of the following blood pressures:

    a) 180/120
    b) 100/60
    c) 100/90
    d) 210/60
    e) 210/110

2. A patient has a lying blood pressure of 130/85 and a standing blood pressure of 95/60. The pulse goes from 76 to 104. Name the diagnostic possibilities.

3. Discuss the significance of the following:

    a) A man has a temperature of 103.6^{0} orally and a pulse rate of 88/min.

    b) A female has a temperature of 100.4^{0} and a pulse rate of 132/min.

    c) An asthmatic, who is cyanotic, has a respiratory rate fall from 40/min. to 14/min. He is still cyanotic, but he looks to be in less distress.

    d) A male with a temperature of 102^{0}, blood pressure of 70/40, pulse rate of 48/min.

4. Define:

   a. Pulse - temperature dissociation
   b. Double quotidian fever
   c. Cheyne - stokes respiration
   d. Pulsus alternans
   e. Shock

5. Name three possible causes of a pulse rate of:

   a. 56/min.
   b. 140/min.

IV. Content Practice Tasks:

1. Observe your partner and write a brief descriptive paragraph of your partner.

V. Bibliography:

Bates, Barbara. A Guide to Physical Examination, Philadelphia, Pa. J.P. Lippincott Company, 1974. Ch. 1 & 2

MODULE NUMBER 3: HEAD AND NECK:

I. Sub-Objectives:

The student will be able to:

1. Inspects and/or palpates the hair, scalp, skull, face and skin of the head and identifies abnormal distribution or texture of hair, abnormal size, shape or symmetry of skull and face.

2. Tests visual acuity and recognizes decreased visual acuity. Inspects position and alignment of the eyes; testing for six fields of gaze and visual fields (peripheral vision) recognizing abnormal position or alignment of eyes (e.g. nystagmus, strabismus, exophthalmus).

3. Inspects the eyebrows, lids, lacrimal apparatus, conjunctiva and sclera, cornea, iris and recognizes abnormalities.

4. Elicit pupillary reaction to light and accomodation noting abnormalities.

5. Use the ophthalmoscope to inspect:

   a) Optic disc
   b) Vessels
   c) General background
   d) Macula recognizing color, swelling and cupping of disc; noting size of arterioles, size of veins and compare. Lesions (hemorrhages and exudates); opacities.

6. Inspect and palpates the external ear. Recognizing swelling, color tenderness, lesions, discharge and deformities.

7. Tests gross hearing and performs Weber and Rinne test, recognizing hearing loss and patterns of conduction and senorineural loss.

8. Use otoscope to inspect canal and tympanic membrane. Recognizing cerumen discharge, foreign bodies in canal; notes color, edema, swelling of canal; identifying color, bulging, retraction, scarring, performation, and fluid level in tympanic membrane.

9. Inspects the nose noting septum, mucosa and turbinates.

10. Palpates the frontal and maxillary sinuses noting tenderness and opacity with light. Recognizing deformity, asymmetry, inflammation, abnormal color, edema exudate, bleeding of the nasal mucosa; perforation and deviation of nasal septum; nasal obstruction.

11. Inspect lips for symmetry, color, edema, lesions, fissures, cracking/crusts, moisture content.

12. Inspect buccal mucosa and roof of mouth for color, pigmentation of lesions, vascular spots, plaques, tumors, ulceration, noting breath odor.

13. Inspect teeth for total number, dental caries, shape and position, coating, color/markings, state of repair.

14. Inspect gums for color, swelling, discoloration, retraction, bleeding, lesions, pus/exudate.

15. Inspect all surfaces of the tongue for symmetry, surface markings, moisture content, color, coating, mobility, texture, nodules or ulcerations.

16. Inspect hard and soft palate, uvula for symmetry/deviations, lesions, clefts, color, mobility, evidence of exudate, edema or ulceration.

17. Inspect anterior tonsillar pillars and posterior pharynx for color, lesions and inflammation.

18. Inspect tonsils for color, size, enlargement, surface markings, exudate, symmetry.

19. Inspect neck for symmetry, masses, edema, scars, dilated vessels, abnormal pulsations, range of motion.

20. Palpate lymph nodes systematically, covering all nodes of the head and neck region noting size, shape, consistency, mobility and tenderness.

21. Palpate trachea for symmetry, deviations from midline.

22. Palpate thyroid gland for symmetry, size, shape, enlargement, tenderness, nodules.

23. Palpate both carotid pulses for symmetry of pulsations and pulse volume and auscultate for bruits.

24. Record examination of head and neck using appropriate terminology.

II. Presentation of Content:

1. Lecture, Demonstration, Practice Lab

2. Film 16mm.

   a. Bates, Barbara. The Head and Neck
   b. Averst. Recognizing Glaucoma

3. Slide/tape presentation - Ophthalmoscopic Exam, National Audiovisual Association

4. Slides of the ear, (Normal and Abnormal), F.N.S.

5. Videotape: Otoscopy in the Inflammations, University of Kentucky

6. Programmed Instruction Units.

   a. "Examination of Head and Neck", AJN, Vol. 75, No. 5
   b. "Examination of the Eye", Part I, AJN, Vol. 74, No. 11; Part II, AJN, Vol. 75, No. 1
   c. "Examination of the Ear", AJN, Vol. 75, No. 3

III. Content study guide:

1. Identify the bones and sutures of the skull.
2. Identify the bones and sinuses of the face.
3. Name and locate the lymph and salivary glands of the face and neck.
4. Describe the relationship and location of the thyroid gland to the manubrium, thyroid cartilage, cricoid cartilage, hyoid bone and sternocleidomastoid muscles.
5. Identify the purpose for palpation of the thyroid.
6. Identify the functions of the bones, sinuses and glands of the face.
7. Identify locations, shape and size of the uvula, pharyngeal tonsil and palatine tonsils.
8. Identify and locate the muscles, lymph nodes, glands, trachea and blood vessels of the neck.
9. Describe normal (expected) range of motion of the head.
10. Describe the internal and external anatomy of the nose.
11. State four functions of the nose.
12. Describe the structures of the mouth and pharynx.
13. Name the full complement of teeth in the adult.
14. Define and describe nasal polyps.
15. List the factors you should note when palpating a lymph node.
16. List five common signs and four common symptoms of tonsillitis.
17. List the main signs and symptoms of acute sinusitis.
18. List three types of abnormalities of the palate.
19. Contrast the signs and symptoms of allergy and the common cold.
20. Define:

    a. Aphthous Ulcer
    b. Torus Palatinus
    c. Herpes Simplex
    d. Thrush
    e. Cheilosis
    f. Vertigo
    g. Dizziness

21. Identify:

    a. Stensen's duct
    b. Wharton's duct

22. List four main characteristics of normal mucous membranes.

23. List four principal kinds of abnormalities to check for when examining the gums.

24. Identify the five principal causes of hoarseness.

25. Identify the external anatomical landmarks of the eye and eyelid.

26. Identify the gross anatomical landmarks of a cross section of the eye including the fundus.

27. Describe the parts of an ophthalmoscope and their function.

28. Identify the structures of the fundus visualized through the ophthalmoscope

29. Identify the significance of the red reflex.

30. Describe the relationship between retinal arteries and veins.

31. Define and briefly describe:

    a. red reflex of the eye
    b. optic atrophy
    c. papilledema
    d. glaucomatous cup
    e. clean wool patches (soft exudates)
    f. exudates
    g. hemorrhages of fundus

32. Describe the normal (expected) findings when no pathology is present from examination of the optic disc, macula, fovea, retina, physiologic cup, retinal arteries and veins as viewed through an opthalmoscope.

33. Describe the physiology of the eye related to visualizing an object.

34. Describe two reflex actions of the eye induced by light rays.

35. Describe the process of eye accommodation, including the three components of the accommodation reaction.

36. Identify the six muscles of the eye.

37. Define extraocular movements.

38. Identify six cardinal positions of gaze and associated nerves.

39. Identify the normal peripheral extent of the field of vision.

40. Interpret the meaning of the numerator and denominator of the fraction expressed in the results of visual acuity using the Snellen Chart.

41. Define:

    a. Entropian
    b. Ectropian
    c. Strabismus
    d. PERRLA
    e. Nystagmus
    f. OD: OS
    g. Ptosis
    h. Dacryocystitis
    i. Marginal blepharitis
    j. Exophthalmos
    k. Hordeolum
    l. Chalazion
    m. Conjunctivitis
    n. Pterygium

42. Identify the three cardinal signs of chronic open-angle glaucoma.

43. Describe the contents and functions of each of the three components of the ear.

44. Describe two pathways of sound vibration.

45. Describe:

    a. Weber Test
    b. Rinne Test
    c. Caloric Test

46. Define:

    a. Tophi
    b. Cerumen

47. Describe normal findings of the tympanic membrane as seen with an otoscope.

48. Explain the rationale for specific positioning of the ear when using the otoscope.

49. Describe the appearance and significance of:

    a. bulging tympanic membrane
    b. retracted tympanic membrane

50. Contrast the signs and symptoms for acute otitis media and serous otitis media.

51. Describe normal (expected) findings when no pathology is present from examination of the head and neck including configuration of the skull; symmetry of the face; assessment of visual acuity and methods of testing; position of the eyelids and globes; extraocular movements; condition of each cornea, scleara and conjunctiva; size, shape and equality of the pupils and their reaction to light and accommodation; visual fields; condition of the optical fundus including the disc, retina and vessels; hearing acuity; condition of the external ears, canals and drums; condition of the nasal passages, mucous membranes and sinuses; condition of the lips, mucosa, teeth, gums, tongue, pharynx, movement of the palate; contour, movement, palpability and position of the trachea and thyroid; condition of the lymph nodes.

IV. Content Practice Tasks:

1. Using Bates' as a guide, perform an examination of the Head and Neck region of your partner, and record.

V. Bibliography:

Bates, Barbara. A Guide to Physical Examination, Philadelphia, Pa. J.P. Lippincott Company, 1974. Ch. 4 .

Atlas: Some Pathological Conditions of the Eye, Ear and Throat, Abbott Lab, North Chicago, Illinois

Collins, Elmer. "Schiotz Tonometry - Pointers for Early Glaucoma Detection", Patient Care, April 1976. p 94-119.

MODULE NUMBER 4: THORAX AND LUNGS:

I. Sub-Objectives:

The student will be able to:

1. Inspect the chest for symmetry, shape (including AP and transverse diameter ratio), slope of ribs, rate and rhythm of breathing, abnormal retraction of interspaces during inspiration, abnormal bulging of interspaces during expiration, respiratory lag or impaired respiratory movement, use of accessory muscles, structural deformities, type and position of clavicles and scapular prominences, spinal deformities.

2. Palpate each side of chest sequentially for tenderness, masses, tactile fremitus, respiratory excursion, ventilatory ability and symmetry.

3. Percuss each side of chest sequentially for intensity, pitch, quality and duration of percussion sounds, identify levels of diaphragm.

4. Auscultate all areas of the chest with the stethescope systematically and sequentially to assess quality, intensity, pitch and duration of breath sounds to identify any adventitious sounds. (e.g. rales, rhonchi, and wheezes).

I. Presentation of Content:

1. Lecture - Discussion: How To Read a Chest X-ray.

2. **Film 16mm: Bates, Barbara. Thorax and Lungs.**

3. Audio Cassette Program with Text: Druger, Goerge. The Chest: Signs and Sounds. Humetries Corporation, Los Angeles, California. 1973, Tapes 1-8.

4. Programmed Instruction Unit: 'Examination of Chest and Lungs', AJN, Vol. 76, No. 9.

5. Handouts:

   a. Breath Sounds, FNS
   b. Summary of Typical Physical Signs in the More Common Respiratory Disease.
   c. Lungs, Borders of the Pleurae, FNS
   d. Percussion Note, FNS

I. Content Study Guide:

1. Identify, locate and briefly describe the structures within the bony framework of the thorax.

2. Identify, locate and briefly describe the components of the respiratory system.

3. Locate the following lines of reference on the anterior thoracic wall:

   a. midsternal line
   b. midclavicular lire

4. Locate the following lines of reference on the lateral thoracic wall:
    a. posterior axillary line
    b. anterior axillary line
    c. midaxillary line

5. Locate the following lines of reference on the posterior thoracic wall:
    a. midspinal (vertebral) line
    b. scapular line

6. Site the significance of the following landmarks:
    a. angle of Louis (manubriosternal junction)
    b. vertebra prominens
    c. inferior angle of the scapula

7. Define the function of the intercostal muscles.

8. Describe the characteristics of normal breathing patterns.

9. List four purposes for inspection of the chest.

10. Define (descriptively):
    a. respiratory excursion
    b. vocal and tactile fremitus
    c. **Cheyne-Stokes Respiration**
    d. sighing respiration
    e. obstructive breathing
    f. barrel chest
    g. pectus excavatum
    h. Pectus carinatum
    i. kyphosis
    j. scoliosis
    k. lordosis
    l. tachypnea
    m. **hyperpnea**
    n. dyspnea
    o. orthopnea
    p. paroxysmal nocturnal dyspnea (P.N.D.)
    q. bronchophony
    r. egophony
    s. whispered pectorilozuy

11. State the normal ratio of the AP to transverse diameter of the chest.

12. Identify at least four observations to be noted during inspection of the chest.

13. Define cyanosis.

14. Identify 3 specific criteria that would indicate nail clubbing.

15. List 3 causes of tracheal deviation.

16. Identify four reasons why the chest is palpated.

17. State the purpose of percussing the chest.

18. Define four characteristics of sound.

19. Describe the technique used to percuss any surface.

20. Describe the quality of the following percussion notes:

    a. flatness
    b. dullness
    c. resonance
    d. hyperresonance
    e. tympany

21. List an example of the following percussion sounds in a normal individual:

    a. flatness
    b. dullness
    c. resonance
    d. tympany

22. List 2 abnormal chest conditions where the following percussion sounds may be noted:

    a. flatness
    b. dullness
    c. hyperresonance
    d. tympany

23. Identify three general areas of lung assessment made by auscultation.

24. Define and distinguish between the following breath sounds:

    a. vesicular
    b. broncho-vesicular
    c. bronchial or tubular
    d. rales (crepitant (fine) or coarse)
    e. rhonchi (sonorous musical rales, bubbling rales)
    f. wheezes (sibilant musical rales)
    g. pleural friction rub

25. Describe normal (expected) findings when no pathology is present from examination of the thorax and lungs including: contour, symmetry, respiratory rate, expansion, position and movement of the diaphragm, findings from palpation, percussion and auscultation in relation to the region examined including adventitious sounds.

26. Explain the significance of:

    a. Unilateral wheeze
    b. Inspiratory wheeze
    c. Expiratory wheeze

27. List 6 general causes for a cough.

28. List a condition in which the following types of cough might be evident:

    a. Dry, non-productive cough - acute onset
    b. Dry, non-productive cough - chronic
    c. Productive cough - acute
    d. Productive cough - chronic

29. List 4 causes for hemoptysis.

IV. Content Practice Tasks:

1. Using Bates' as a guide, draw in your partner with a wax pencil noting the theoretical subline of the underlying lungs. (Posterior, anterior and oblique viens.) Attempt to get a three dimensional concept of the lungs, their lobes and tissues. Using landmark guide, find all anatomical parts listed and mark with pencil as indicated on your partner (outline from University of Rochester)

2. Perform a complete examination on your partner of the Thorax and Lung areas, write up your findings.

3. Review breath sound tapes.

V. Bibliography:

Bates, Barbara. A Guide To Physical Examination, Philadelphia, Pa. J.P. Lippincott Company, 1974. Ch. 5.

Delaney, Mart T. 'Examining the Chest Part I: The Lungs', Nursing 75, Vol. 5, No. 8, August, p 12-14.

Durger, George. The Chest: Signs and Sounds, Humetrics Corporation. Los Angeles, California, 1973.

University of Rochester
SCHOOL OF NURSING

Landmarks of the Thorax
Placement of Lungs and Heart

1. Using one of the physical diagnosis books as a guide, locate on your laboratory partner the following.

Landmarks

I. Anterior Thorax

1. Identify suprasternal notch.
2. Identify angle of Louis
3. Identify mid-sternal line, left and right sternal borders.
4. Identify mid-clavicular line, left and right.
5. Identify anterior axillary line, mid-axillary line, posterior axillary line, right and left.
6. **Identify costal angle.**
7. Place a dot at 6th rib at mid-clavicular line, right and left.
8. Place a dot at 8th rib at mid-axillary line, right and left (lower border of anterior lung).
9. Place a dot at 5th rib at mid-axillary line, right and left.
10. Place a dot at 4th rib at sternal border, right and left.

II. Posterior Thorax

1. Identify vertebral line
2. Identify scapular line
3. Identify spinous process of C_7 (flex head, most prominent spinous process is usually C_7 or T_1)
4. Place a dot at spinous process of T_3
5. Identify spinous process of T_5 (directly posterior to angle of Louis)
6. Place a dot at spinous process of T_{10}

III. The Lungs

1. Draw a line from the dot at 5th mid-axillary line to the dot at the 4th rib at right sternal border (horizontal or minor fissure).

2. Draw a line from the dot at the 6th rib mid-clavicular line to the dot at the right and left 5th rib, mid-axillary line (RLL LLL).

3. Draw a line from right and left sternal borders at the level of the second intercostal space over the shoulders to the right and left vertebral borders at the level of T_3.

4. Draw a line from T_3 to 5th rib at the mid-axillary line, then to the dot at the 6th rib mid-clavicular (right and left), (oblique fissure).

5. Draw a line from the vertebral borders at the level of T_{10} through the dot of the 8th rib mix-axillary to the dot of 6th rib mid-clavicular (right and left), (inferior border of lung).

6. Draw a line from the sternal borders at the level of the 2nd intercostal space to costal angle, (right and left).

Prepared by:

Mary Wemett
University of Rochester
School of Nursing

MW:cc
5/75

MODULE NUMBER 5: HEART, PRESSURES AND PULSES, PERIPHERAL VASCULAR SYSTEM

I. Sub-Objectives:

The student will be able to:

1. Inspect and palpate the precordium locating the PMI and recognizing abnormal pulsations, thrills, leans or lifts and valvular closure vibrations.
2. Auscultate heart sounds using the bell and diaphragm of the stethescope, sequentially over the aortic, pulmonic, Erb's, tricuspid and mitral areas in the supine, left lateral and sitting positions.
3. Auscultate heart sounds as to pitch, intensity, quality, duration, rate and rhythm, comparing S_1 and S_2 noting any splitting, murmurs and/or gallops.
4. Describes heart murmurs in terms of timing, location, radiation, intensity, pitch and quality.
5. Inspects neck veins for an estimation of venous pressure and venous pulsations.
6. Inspects and palpates the extremities, noting color, size, symmetry, hair distribution, lymph nodes, pigmentations, rashes, scars, venous pattern, edema, ulcers, tenderness, positive Homan's sign.
7. Palpates the following peripheral pulses: brachial, radial, femeral, popliteal, dorsalis pedis, posterior tibial, noting inequality or absence.

II. Presentation of Content:

1. Lecture, Demonstration, Practice Lab, Model of Heart, Method of Taking EKG.
2. Film 16mm: Bates, Barbara.
   a. "Heart"
   b. "Pulses and Pressures"
   c. "Peripheral Vascular System"
3. Videotape:
   a. Auscultation of the Heart, University of Kentucky, Lexington, Ky.
   b. Electrocardiography and the Arrythmias, University of Kentucky, Lexington, Ky.
   c. Format for Interpreting EKG, University of Kentucky, Lexington, Ky.
4. Records and cassette tapes:
   a. Cardiac Auscultation. Merck, Sharpe & Dohme. No. 1-7.
   b. Interpreting Heart Sounds. Roche Lab. Part 1, No. 1-3, 9-11.
   c. Cardiac Auscultation. National Audiovisual Corporation.

5. Handouts:

   a. The Heart As A Pump, Selkert
   b. Arrhythmia Recognition and Identification. Thomas Dean, M.D., F.N.S.
   c. The Recognition of Conditions Often Confused with Angina Pectoris

6. Van Meter, Margaret and Lavine, Peter G.
   "What Every Nurse Should Know About EKG's"
   Part 1-4, Nursing '75, April, p 19-27
   May, p 37-43
   June, p 19-25
   July, p 31-36

III. Content Study Guide:

1. Identify and locate: arteries and veins related to the heart; heart chambers and valves; covering and walls of the heart; modified cardiac muscles; nerve supply of the heart.

2. Locate and identify parts of the heart forming the: base, apex, right, left and inferior boarders.

3. Describe the sequential events in the cardiac cycle including the inter-relationships of the pressures on the heart chambers and the position and movement of the valves.

4. Describe the normal pattern of electrical conduction which stimulates and coordinates muscular contractions of the cardiac chambers.

5. Define and briefly describe:

   a. first and second heart sounds (S_1 & S_2)
   b. cardiac output or "minute volume"
   c. murmur
   d. bruit
   e. splitting
   f. stroke volume
   g. ejection click
   h. gallop rhythm

6. Differentiate between physiological and pathological splitting; murmur.

7. Identify six characteristics used to describe heart murmurs.

8. Identify the scale for grading the intensity of heart murmurs according to Freeman and Levine.

9. Compare the normal intensity of the second sound in the aortic and pulmonic areas. Explain the significance of $P_2 > A_2$. (DeGowan p 355)

10. Identify two conditions in which PMI would be displaced.

11. Name and locate seven arterial peripheral pulses.

12. Identify the anatomical location of the following palpation areas and indicate what pathological conditions may be recognized for each:
    - a. aortic area
    - b. pulmonary area
    - c. right ventricular area
    - d. apical area (PMI)
    - e. epigastric area

13. Identify the anatomical location of the following auscultation areas:
    - a. aortic
    - b. pulmonic
    - c. Erb's Point
    - d. tricuspid area
    - e. mitral area

14. Compare the purpose and technique of using the diaphragm and the bell of the stethoscope.

15. Explain the advange of using the following positions during auscultation:
    - a. left lateral decubitus
    - b. sitting position, leaning forward.

16. Identify 6 mechanisms which cause heart murmurs.

17. Define (descriptively):
    - a. systolic murmur
    - b. diastolic murmur
    - c. regurgitant murmur
    - d. ejection murmur
    - e. stenotic valve
    - f. insufficient valve
    - g. functional murmurs

18. List the 4 valvular conditions that cause:
    - a. systolic murmurs
    - b. diastolic murmurs

19. Differantiate and state significance of S_3 (ventricular) gallop and S_4 (atrial) gallop.

20. Describe technique for auscultation for gallops.

21. Describe factors which would differentiate between a carotid bruit and a radiating aortic stenosis murmur.

22. Describe the normal (expected) findings when no pathology is present from the examination of the heart including condition of the neck veins, venous pulsations and jugular venous pressure; amplitude, type and equality of the arterial pulses (including quality of the arterial wall); location of the PMI; auscultatory findings including rate and rhythm of the heart, the characteristics of S_1 and S_2, respiratory influences and characteristics of any murmurs.

23. Identify the electrical event, mechanical action, and duration for the following EKG patterns:

    a. P wave
    b. P-R internal
    c. QRS complex
    d. ST segment
    e. T wave

24. Draw a normal EKG pattern and label the above on it.

25. Define:

    a. arrhythmia
    b. bradycardia
    c. tachycardia
    d. flutter
    e. fibrillation
    f. heart block - 1^{o}, 2^{o}, 3^{o}
    g. premature atrial beats
    h. premature ventricular contractions

26. Explain the method of calculation for atrial and ventricular rate and rhythm from an EKG pattern.

27. Describe a systematic way of analyzing an EKG.

28. Identify the characteristics of the following arrhythmias:

    a. atrial fibrillation
    b. atrial flutter
    c. paroxysmal atrial tachycardia
    d. complete (3^{o}) heart block (A-V dissociation)
    e. premature ventricular contraction
    f. ventricular tachycardia
    g. ventricular fibrillation

29. Describe the technique for obtaining a:

    a. rhythm strip
    b. 12 lead EKG

    and explain the value of each.

30. Identify the external and internal jugular pulsations and compare with carotid pulsations.

31. Identify the technique and significance of estimating jugular venous pressure (JVP).

IV. Content Practice Tasks:

1. Using Bates as a guide, draw with a wax pencil on your partner's chest, the theoretical silhouette of the heart, including right atrium, right ventricle, left ventricle aorta and auscultory areas.

   Using landmark guide, find all anatomical parts listed and mark as pencil indicated on your partner. (Outline from the University of Rochester.)

University of Rochester
SCHOOL OF NURSING

Heart

1. Place a dot at apical impulse (in the 5th interspace 7 to 9 cm from mid-sternal line (lower of left ventricle border)
2. Place a dot at the point the body of the sternum connects to the 5th ICS xiphoid process (lower border of right ventricle)
3. Place a dot close to, but left of sternal border at 3 ICS third inter-costal space (left atrium).
4. Connect above dots.

Border of Cardiac Dullness	
3rd ICS	4 cm
4th ICS	7 cm
5th ICS	10 cm

2. Perform a complete examination of the heart, pulses and pressures and peripheral vascular system on your partner, write up your findings.
3. Review heart sound records or tapes.
4. Analyze the attached EKG and compare your results with the key.

EKG EXERCISE:

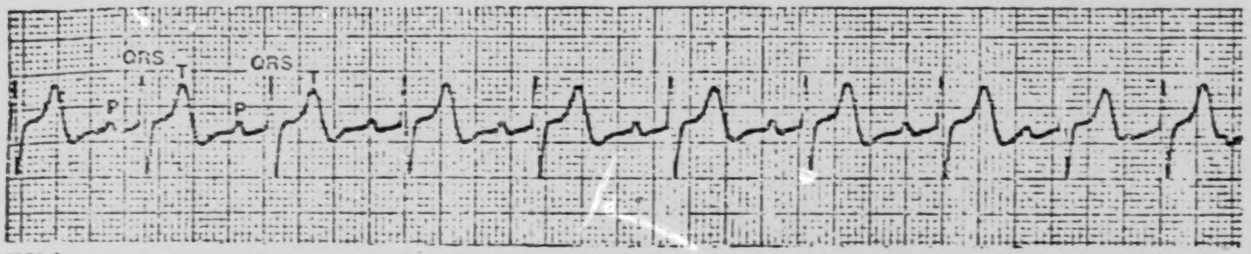

Figure 1 — EKG EXERCISE

1. Rate
   (a) Atrial ____________________
   (b) Ventricular ____________________

2. Rhythm
   (a) Atrial ____________________
   (b) Ventricular ____________________

3. Conduction
   (a) P-R interval ____________________
   (b) QRS duration ____________________

4. Configuration and location
   (a) P wave ____________________
   (b) QRS complex ____________________
   (c) S-T segment ____________________
   (d) T wave ____________________

5. Summary report to the physician ____________________

____

____

____

*Modified chest lead is an amplified lead VI.

KEY---ANSWERS TO EKG EXERCISE:

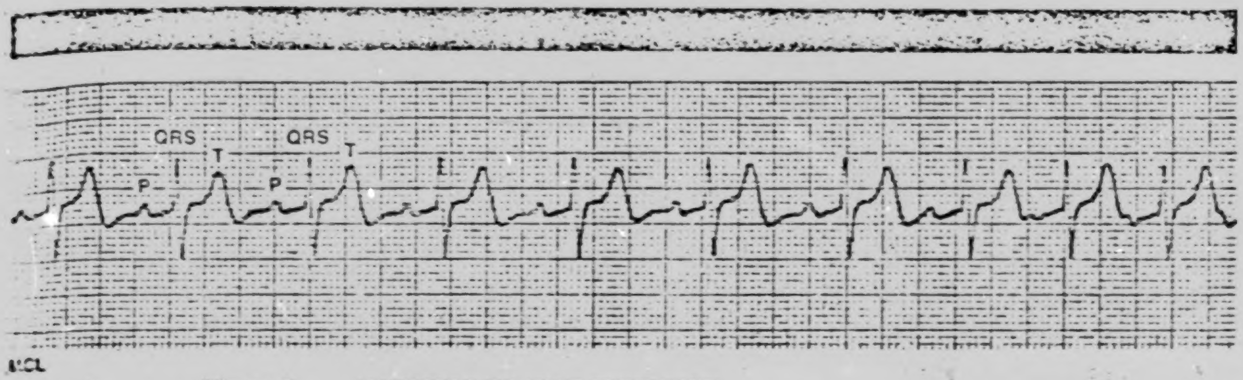

Figure 2 — ANSWERS TO EKG EXERCISE

1. Rate
   - (a) Atrial — *84 (1500 ÷ 17) beats per min.*
   - (b) Ventricular — *84 beats per min.*

2. Rhythm
   - (a) Atrial — *initially regular, then slightly irregular*
   - (b) Ventricular — *initially regular, then slightly irregular*

3. Conduction
   - (a)P-R interval — *.20 seconds (5 x .04)*
   - (b) QRS duration — *.10 seconds (2½ x .04)*

4. Configuration and location
   - (a) P wave — *mostly upright but some inverted; precedes QRS*
   - (b) QRS complex — *narrow, uniform size and shape; follows P wave*
   - (c) S-T segment — *slightly elevated*
   - (d) T wave — *tall, tent-shaped*

5. Summary report to the physician — *Heart rate is 84 with some irregularity in atrial and ventricular rhythms. The QRS complex has not changed size, shape or direction. Some P waves have become inverted. The P-R interval and QRS duration are normal.*

V. Bibliography:

American Heart Association. Examination of the Heart, Part 1-5, New York, N.Y.

American Heart Association. Hypertension - Office Evaluation, New York, N.Y.

Bates, Barbara. A Guide to Physical Examination, Philadelphia, Pa. J.P. Lippincott Company, 1974, Ch. 6, 7, 13.

California Heart Association. Introduction to Arrythmia Recognition, San Francisco, California.

Coodley, Eugene L. "Significance of Serum Enzymes", AJN, Vol. 68, No. 2, February 1968, p 301-304.

Delaney, Mary T. "Examining the Chest Part II: The Heart", Nursing 75, Vol. 5, No. 9, September, p 41-46.

Imbruce, Richard P. "Are You Underusing Blood Gas Analysis?", Patient Care, April 1, 1976, p 120-128.

Smith, Aynsley M; Theirer, Judith A.; Huang, Sheila H. "Serum Enzymes in Myocardial Infarction", AJN, Vol. 73, No. 2, February 1973, p 277-279.

Westfall, Una Elizabeth. "Electrical and Mechanical Events in the Cardiac Cycle", AJN, Vol. 76, No. 2, February 1976, p 231-235.

ODULE NUMBER 6: BREASTS AND AXILLAE

. Sub-Objectives:

The student will be able to:

1. Inspect both breasts for symmetry, size, skin color, vascular pattern, edema, bulging, masses, retraction while in the following four positions:
    1. sitting with arms and chest muscles at rest
    2. sitting with arms raised above head
    3. sitting with arms and chest muscles under tension
    4. supine position
2. Inspect nipples for skin texture of areola, size, pigment, position, inversion, retraction, discharge or lesions.
3. Inspect both axilla for rashes, lesions or edema (sitting position).
4. Palpate both breasts by quadrants or in a concentric manner to include the nipple and areola noting consistency, texture, mobility, tenderness, masses and nipple discharge (supine position).
5. Describe breast lesions in terms of location, size (in centimeters), shape, consistency, mobility, delineation in relationship to surrounding tissue and tenderness.

6. Record examination and draw a diagram showing location of any lesions found on examination.

. Presentation of Content:

1. Lecture - Discussion

2. Film 16mm: Bates, Barbara, Breasts and Axillae.

3. Handouts:

    a. Examination of the Breast, Novak's Textbook of Gynecology, p 85-86.
    b. Routine Breast Examination, FNS

. Content Study Guide:

1. Describe three principle components of female breast tissue.
2. Describe the location of the female breasts in terms of peripheral structures.
3. Locate and describe the anatomical components of the breast and function of each.
4. Identify two mechanisms by which breasts are supported.
5. Identify four types of nipple discharge and their probable cause.
6. Distinguish between nipple inversion and nipple retraction.
7. Identify the effects of estrogen, progesterone and prolactin on breast development.
8. Describe the axilla in terms of its location, shape, structure contributing to its formation.
9. Locate each of the breast lymph nodes and describe the direction of their drainage.
10. Locate the axillary nodes and identify three other groups of lymph nodes which have channels draining into these axillary nodes.

11. Describe the effects of pituitary and ovarian hormones on the mammary glands and breasts throughout the menstrual cycle.
12. Identify the visable signs of breast cancer.
13. Identify four characteristics of the breast used during inspection.
14. Identify seven characteristics used to describe breast nodules.
15. Differentiate between the characteristics of:

    a. Cystic disease
    b. Adenofibroma
    c. Cancer

16. Describe the normal findings from examination of the breast when no pathology is present including symmetry; nipple characteristics; evidence of masses or tenderness (including axillae); contour and consistency appropriate for age and parity.
17. Define gynecomastia, galactorrhea.
18. Identify the recommended time in the menstrual cycle for breast examination.

V. Content Practice Tasks:

1. Perform a complete examination of your partner's breasts, write up your findings and descriptions.

V. Bibliography:

Bates, Barbara. A Guide to Physical Examination, Philadelphia, Pa. J.P. Lippincott Company, 1974, Ch. 8.

MODULE NUMBER 7: ABDOMEN

I. Sub-Objectives:

The Student will be able to:

1. Inspect abdominal skin for color, scars, striae, dilated vessels, lesions, umbilical abnormalities.
2. Inspect abdomen for symmetry, shape and contour, noting any distention, edema, abnormal pulsations, visible loops of distended bowels, peristaltic activity, distribution of hair.
3. Auscultate abdomen for bowel sounds in each of the four quadrants and epigastrium, also recognizing bruits and venous hums.
4. Percuss abdomen lightly over each of the four quadrants for presence of fluid, masses, organ borders such as liver, organ enlargement, noting sound of tympany to shift of dullness.
5. Palpate lightly in each of the four quadrants for abdominal tenderness or pain, muscular resistance, superficial organs and masses including the inguinal regions for lymphadenopathy.
6. Palpate deeply to delineate normally palpated organs and to identify enlarged abdominal organs, masses, tenderness or pain (including rebound).
7. Inspect and palpate bilaterally the femoral area and inguinal rings for hernias.

II. Presentation of Content:

1. Lecture - Discussion
2. Film 16mm: Bates, Barbara. 'Abdomen'
3. Programmed Instruction Unit: "Examination of the Abdomen", AJN.

III. Content Study Guide:

1. Identify the boundaries of the abdomen.
2. Identify the four quadrants of the abdomen.
3. Locate each structure found in the four quadrants.
4. Describe normal peristalsis and accompanying bowel sounds.
5. Identify three general features of the abdomen described during inspection. Identify the specific characteristics for each general feature.
6. State two reasons for auscultating the abdomen.
7. Identify the criteria for stating that bowel sounds are absent.
8. State two reasons for percussing the abdomen.
9. State three reasons for light palpation of the abdomen; two reasons for deep palpation of the abdomen.
10. Describe the technique used with light abdominal palpation; with deep abdominal palpation.
11. Describe the normal size and location of the liver and spleen and indicate the technique for making that determination.
12. List the organs that are normally palpated abdominally.
13. List the "six F's" that can cause abdominal distention.
14. Identify seven characteristics used to describe an enlarged organ or mass.
15. Define (in descriptive terms) and note significance of:
    a. ascites
    b. hernia
    c. striae
    d. rebound tenderness (peritoneal reflex)
    e. costal vertebral tenderness
    f. diastasis recti
    g. abdominal bruits
    h. abdominal friction rub
    i. guarding

16. Describe the technique and significance of shifting dullness; fluid wave.
17. Define referred pain.
18. List the abdominal conditions which cause referred pain to:
    a. the shoulder
    b. the back
    c. the groin or testis
19. List the common causes for:
    a. epigastric pain
    b. peri-umbilical or mid-abdominal pain.
    c. lower abdominal or suprapubic pain
20. List the common causes of abdominal pain of:
    a. immediate onset
    b. gradual onset
21. Describe normal findings (with no pathology present) upon examination of abdomen including condition of the abdominal wall; size, symmetry, muscle tone, presence or absence of surgical scars, tenderness, presence of masses; findings in palpation of the liver, kidneys and spleen; findings of auscultation regarding peristaltic activity and presence or absence of bruits; description of inguinal lymph nodes; presence or absence of inguinal or femoral hernias.

IV. Content Practice Tasks:

1. Perform a complete examination of the abdomen on your partner; write up all findings and descriptions.

V. Bibliography:

Aspects of Abdominal Pain, Hoffman-LaRoche, Inc, Nutley, New Jersey, 1968.

Bates, Barbara. A Guide to Physical Examination, Philadelphia, Pa. J.P. Lippincott Company, 1974, Ch. 9

Cope, Sir Zachary. The Early Diagnosis of the Acute Abdomen, London, Oxford University Press, 1972, p 1-47.

Robins, A.H. G.I. Series: Physical Examination of the Abdomen, A.H. Robins Company, Richmond, Va.

MODULE NUMBER 8: FEMALE GENITALIA

I. Sub-Objectives:

The student will be able to:

1. Inspect the external female genitalia (vulva, labia, clitoris, urethra, introitus, hymen) noting hair distribution, skin recognizing inflammation, ulceration, discharge, swelling, nodules, varicosities, scars.

2. Palpate pelvic tone noting cystocele, rectocele and uterine prolapse.

3. Perform speculum examination inspecting vagina; noting color, mucosa, inflammation, contour, size of or, color, friability, discharge and obtaining pap and G.C. smear with wet prep (if indicated).

4. Perform bimanual examination noting size, shape and position of uterus, size and shape of ovaries recognizing adnexal tenderness, enlargement, masses and fixation of uterus.

5. Palpates Bartholins and Skenes glands and milk urethra (if indicated) for discharge.

6. Perform recto-vaginal exam noting consistency of septum and recognizing abnormalities.

II. Presentation of Content:

1. Lecture - Discussion

2. Demonstration with Ginny Doll

3. Film 16mm: Female Pelvic Exam, Lilly.

4. Programmed Instruction Unit: Determining Uterine Position, Long, Phyllis.

5. Handouts:

   a. Pelvic Examination, FNS Procedure
   b. Abdominal - Pelvic Examination, Novak
   c. The Gynecologic History, FNS
   d. Instructions for Taking Pap Smears, FNS
   e. Pap Smear and Tissue follow-up, FNS
   f. GC Culture, FNS

III. Content Study Guide:

1. Identify the following structures of the external female genitalia on illustration (Bates) p 188.

   a. Labia Majora
   b. Labia Minora
   c. Mons pubis
   d. Escutcheon
   e. Prepuce
   f. Clitoris
   g. Urethral orifice
   h. Orificof Skene's gland
   i. Vestibule
   j. Perineum
   k. Hymen
   l. Vaginal orifice (introitus)
   m. Orifice of Bartholins gland
   n. Anus

2. Identify the following structures and regions of the internal female genitalia on an illustration:
    a. Vagina
    b. Vaginal fornices: Anterior, posterior, lateral
    c. Posterior cul-de-sac
    d. Rectovaginal septum
    e. Uterus: corpus, fundus, cornua, cervix (internal os, external os, squamo-columbar junction)
    f. Fallopian tubes
    g. Ovaries
    h. Urinary bladder
    i. Rectum
    j. Perineum
3. Describe the following uterine position and terms:
    a. Anteverted
    b. Anteflexed
    c. Mid-position
    d. Retroverted
    e. Retroflexed
    f. Dextro-rotated
    g. Levo-rotated

    and identify the steps in determining uterine position.
4. Describe what is meant by the adnexal region. Identify the structures located there.
5. Locate the following ligaments that support the uterus.
    a) Round
    b) Broad
    c) Cardinal
    d) Uterosacral
6. Locate the following bones of the pelvis:
    a) Pubis
    b) Sacrum
    c) Coccyx
    d) Iluim
    e) Ischium
7. List the equipment needed to perform a pelvic exam.
8. Describe the procedure for taking a
    a) Pap Smear
    b) ~~GG~~ Smear and Culture
    c) Wet Smear

9. Identify ways to allaying the patients' anxiety over having a pelvic exam.

10. State the factors which influence the selection of the proper speculum.

11. Identify the parts of the speculum and their functions.

12. List the progression of events in performing the pelvic exam.

13. Describe cystocele, rectocele and uterine prolapse.

14. Describe the normal size, shape and position of the uterus and ovaries.

15. Describe the causative organism, signs, symptoms and diagnostic procedures for:

    a. Monilia vaginitis
    b. Trichimonas vaginitis
    c. Gonorrheal vaginitis
    d. Hemophilus vaginitis
    e. Atrophic vaginitis
    f. Syphilis

16. Define (descriptively):

    a. Cervical eversion
    b. Cervical erosion
    c. Nabothian Cyst
    d. Cervical polyp
    e. Cervical carcinoma

IV. Content Practice Tasks:

1. Perform a complete pelvic examination on the Ginny Doll and write up your findings.

V. Bibliography:

Atlas: Cervical Pathology, Abbott Laboratories, North Chicago, Ill.

Bates, Barbara. A Guide to Physical Examination, Philadelphia, Pa. J.P. Lippincott Company, 1974, Ch. II.

Haynes, Douglas. Essentials of the Gynecologic History and Examination, Smith/Kline Corporation, Philadelphia, Pa., 1965.

Magee, Joni. "The Pelvic Examination: A View from the Other End of the Table". Annals of Internal Medicine, Vol. 83, No. 4, October 1975, p 563-564.

Okrent, Shirley. A Clinical Guide to the Intrauterine Device and the Vaginal Diaphragm, Wantagh, New York, 1974, p 4-15.

Vaginitis, Ortho Pharmaceutical Corporation 1969.

MODULE NUMBER 9: MALE GENITALIA

I. Sub-Objectives:

The student will be able to:

1. Inspect the penis and scrotum observing the skin, prepuce , (if present, check for phimosis) glands, urethral meatus and scrotal sac noting lesions, inflammation, edema, discharge and nodules.

2. Palpate shaft of penis noting size, contour, tenderness and induration.

3. Palpate each testis and epididymis and spermatic cord up to inguinal ring, notice size, shape, consistency, tenderness, nodules, swellings (if any swelling present, trans-illuminate scrotum), or hernias.

II. Presentation of Content:

1. Lecture-Discussion

2. Film 16mm: Bates, Barbara, Male Genitalia.

III. Content Study Guide:

1. Identify, locate and briefly describe the anatomy of the male genitalia.

2. Describe and locate external inguinal ring and femeral canal, differentiating between femeral and inguinal hernias.

3. Define:

   a. hypospadias
   b. syphlitic chancre
   c. hydrocele
   d. tuberculous epididymitis
   e. varicocele
   f. torsion of the testis

IV. Content Practice Tasks:

1. Perform a complete male genitalia examination and record your findings and descriptions.

V. Bibliography:

Bates, Barbara. A Guide To Physical Examination, Philadelphia, Pa., J.P. Lippincott Company, 1974, Ch. 10.

MODULE NUMBER 10: ANUS AND RECTUM

I. Sub-Objectives:

The student will be able to:

1. Inspect the anus area identifying inflammation, hemorhoids, fissures and fistula, nodules.
2. Palpates rectum noting sphincter tone, tenderness, irregularities, nodules, strictures and polyps.
3. Palpate the prostate gland for size, shape, tenderness, consistency and nodularity.

II. Presentation of Content:

1. Lecture - Discussion
2. Film 16mm: Bates, Barbara. Anus and Rectum

III. Content Study Guide:

1. Identify external and internal sphincter, general contour of prostate.
2. Define and describe characteristics of:
    - a. fistula
    - b. fissure
    - c. pilonidal cyst
    - d. pedunculated polyps
    - e. sessile polyps
    - f. benign prostatic hypertrophy
    - g. prostatitis
    - h. external hemorrhoid
    - i. internal hemorrhoid
    - j. carcinoma of the prostate
    - k. carcinoma of the rectum

IV. Content Practice Tasks:

1. Perform a complete rectal examination and record findings and descriptions.

V. Bibliography:

Bates, Barbara. A Guide To Physical Examination, Philadelphia, Pa., J.P. Lippincott Company, 1974, Ch. 12.

DeGowin and DeGowin. Bedside Diagnostic Examination, New York, The Macmillan Company, 1969, p 531-543.

MODULE NUMBER 11: MUSCULO-SKELETAL SYSTEM

I. Sub-Objectives:

The student will be able to:

1. Observe patients at rest, during ambulation, sitting and throughout examination for limited range of motion, musculo- skeletal deformities, pain on movement.
2. Inspect and palpates all body parts for symmetry, size, redness, heat swelling, strength, condition of surrounding tissue (e.g. muscle atrophy), crepitations and contractures.
3. Test all body parts for range of motion noting any limitations.

II. Presentation of Content:

1. Lecture - Discussion
2. Film 16mm: Bates, Barbara. Musculoskeletal System.
3. Handouts:
   a. Diagrams: Skelton, Anterior, Posterior Views
   Major Muscle Groups, Kimber, Gray.

III. Content Study Guide:

1. Review the anatomy of the major muscle groups and bony structure of major joints (e.g., wrist, knee, ankle, elbow, shoulder, hip).
2. Identify the parts of the spine and know its normal curvature.
3. Define:
   a. abduction
   b. adduction
   c. eversion
   d. inversion
   e. pronation
   f. supination
   g. subluxation
   h. crepitus
   i. effusion
   j. bunion
   k. hammer toe
   l. equines valgus
   m. equines calcaneus
   n. ankyloses
   o. bulge sign
   p. pes planus
   q. kyphosis
   r. lordosis
   s. scoliosis
   t. synovitis
   u. draw sign
   v. bursa
   w. Heberden's nodes

IV. Content Practice Tasks:

1. Practice: Using the text and a skeleton as your guide, draw a line or dot or X (whichever is appropriate) on your partner to indicate the location of:

   a. The temporomandibular joint
   b. The metacarpophalangeal joint of the middle finger
   c. The proximal interphalangeal joint of the ring finger
   d. The distal interphalangeal joint of the little finger
   e. The dorsal aspect of the wrist joint
   f. The olecranon process
   g. The lateral epicondyle of the humerus
   h. The sternoclavicular joint
   i. The coracoid process
   j. The acromioclavicular joint
   k. The greater tubercle of the humerus
   connect these 3 points to form a triangle
   l. The head of the first metatarsal in the sole of the foot
   m. The anterior aspect of the ankle joint
   n. The medial condyle of the knee
   o. The lateral condyle of the knee
   p. The tibial tuberosity
   q. The head of the fibula
   connect these 3 points to form a triangle
   r. The patella
   s. The knee joint itself

2. Perform a complete musculo-skeletal examination on your partner, record your findings and descriptions.

V. Bibliography:

Bates, Barbara. A Guide To Physical Examination, Philadelphia, Pa. J.P. Lippincott Company, 1974, Ch. 14.

MODULE NUMBER 12: NEUROLOGICAL SYSTEM

I. Sub-Objectives:

The student will be able to:

1. Appraises mental status by observing general appearance and behavior, level of conciousness, intelligience, emotional status and thought content.

2. Inspects and evaluates the function of the twelve cranial nerves noting abnormalities.

3. Inspects and evaluates neuro-sensory system using pain, temperature, light touch, vibration, position, discriminitive sensation.

4. Inspects and evaluates neuro-motor system by observing gait, Romberg, knee bend, hop, walk on toes and heels, arms held forward and hand grip to assess muscle symmetry, strength, balance and coordination.

5. Elicit deep tendon and superficial reflexes.

II. Presentation of Content

1. Lecture - Discussion
2. Film 16mm: Bates, Barbara. Neurological Systems, Part I & Part II.
3. Handouts;
    a. Neurological Exam, FNS
    b. A Cookbook Approach to the Neurological Exam, FNS
    c. Neurosis and Psychosis, Dr. Thomas Dean
4. Programmed Instruction Units: Mechner, Frances. "Patient Assessment: Neurological Examination", Part I, II, III, AJN, Vol. 75, No. 9, p 1-24
Vol. 75, No. 11, p 1-24
Vol. 76, No. 4, p 1-25

III. Content Study Guide:

1. Locate the three sections of the brain and components of each.
2. Identify the functions controlled by each section of the brain.
3. Name and state the functions of each of the twelve cranial nerves.
4. Describe the pathway of the reflex arc which stimulates a muscle to contract.
5. Identify five factors upon which a deep tendon reflex depends.
6. Identify three higher motor pathways and describe function of each.
7. Describe the sensory pathway which gives rise to conscious sensation.
8. Identify and describe technique for eliciting:
    a. three superficial tendon reflexes.
    b. five deep tendon reflexes.
9. Describe the criteria used to grade reflexes from 0 to 5+.
10. Define:
    a. Kernig's sign
    b. Romberg test
    c. Brudzinski sign
    d. stereognosis
    e. fasciculation
    f. ataxia
    g. clonus
    h. tics
    i. athetosis
    j. myoclonus
    k. chorea
    l. agnosis
    m. aphasia

11. Describe the levels of consciousness.
12. Describe the normal findings (when no pathology is present) from an examination of the neurological system including assessment of mental status (level of consciousness, manner, mood, orientation, memory, intellectual function and insight), station and gait, function of the cranial nerves, motor function (assessment of symmetry, movements, strength, tone), reflexes, sensory function (pain and light-touch sensation, vibratory and position sense and stereognosis).

13. Differentiate between neurosis and psychosis.
14. Describe symptoms of depression.
15. Define stages of anxiety.

IV. Content Practice Tasks:

1. Perform a complete examination of the neurological system on your partner, practicing the differences between a screening neurological and a complete neurological assessment. Plan how to integrate the neurological examination into the complete physical assessment of the patient.

V. Bibliography:

Bates, Barbara. A Guide To Physical Examination, Philadelphia, Pa., J.P. Lippincott Company, 1974, Ch. 15, 16.

DeJong, Russell N. Essentials of the Neurological Examination, Philadelphia, Pa., Smith/Kline Corporation, 1974.

MODULE NUMBER 13: SKIN

I. Sub-Objectives:

The student will be able to:

1. Inspect and palpate the skin noting color, temperature, pigmentation, moisture, texture, vascularity, turgor, mobility, hair distribution, recognizing lesions, scars, bruising, edema, tenderness, inflammation.

II. Presentation of Content:
1. Lecture - Discussion
2. Medcom Slides: 35mm

III. Content Study Guide:

1. Review anatomy and physiology of the skin.
2. Define primary and secondary lesions.
3. Describe:
   a. macule
   b. papule
   c. wheal
   d. nodule
   e. tumor
   f. vesicle
   g. bulla
   h. pustule
4. Describe:
   a. oozing and crusting
   b. plaque
   c. scales
   d. fissure
   e. erosion
   f. ulcer
   g. scar
   h. atrophy
   i. scab
   j. callus
5. Identify 4 characteristics used to describe lesions.
6. Identify skin and nail changes associated with heart and lung disease.
7. Describe and explain significance of:
   a) cherry angioma
   b) spider angioma
   c) venous star
   d) petechia
   e) echymosis
8. Define the following descriptive terms:
   a) annular
   b) linear
   c) circumscribed
   d) clustered

IV. Content Practice Tasks:

1. Perform a complete examination of your partner's skin, hair, and nails, record your findings and descriptions.

V. Bibliography:

Atlas: Common Skin Diseases, Abbott Laboratories, North Chicago, Ill.

Bates, Barbara. A Guide To Physical Examination, Philadelphia, Pa., J.P. Lippincott Company, 1974, Ch. 3.

Johnson & Sulzberger, Patient Care, October 1974, p 142-167.

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APPENDIX H

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1370-77

MEDICAL BELIEFS, PAST EXPERIENCE AND THE USE OF HEALTH SERVICES IN A RURAL APPALACHIAN COMMUNITY

By

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Department of Behavioral Science

University of Kentucky Medical Center

Lexington, Kentucky

1974

Chapter 1

WOOTON AND ITS PEOPLE

Like so many other rural Appalachian communities, the area centering in the crossroads settlement of Wooton refuses to stand still either literally or figuratively. Both its physical boundaries and demographic characteristics have been changing with increasing speed in recent decades as improved roads and generally improving economic conditions have linked the people ever more firmly to Wooton as a small service center and to other parts of the county, state and nation. As a result, neighborhoods formerly separated from each other along mountain creeks and branches are now part of a larger community which in turn has all-weather access to the county seat of Hyden 6 miles to the west and to Hazard, the Perry county seat, 14 miles north and east. Another 19 miles of macadam turn southward up Cutshin creek and across the county line to the large underground coal mines at Leatherwood where many Wooton area residents work.

One of the newest additions to the community is a Mountain Comprehensive Health Corporation clinic located near W.B. Muncy central elementary school just off the half mile stretch of highway where the Baptist and Presbyterian churches, a multipurpose OEO-Community Action Center, Wooton post office and half a dozen commercial structures constitute the visible center of town. The MCHC Family Health Center, better known as Wooton Clinic, thus provided a convenient base in the summer and fall of 1973 from which to assess the relation of local beliefs and past experiences with health professionals to the utilization of comprehensive services by persons not previously exposed to this type of primary health care facility. This is not to deny the importance of earlier efforts to meet the community's basic health needs. The Presbyterian church, for example, began educational work there in the 1920's, when it established the county's first high school and also brought in the first public health nurse who for several years maintained a tiny hospital dispensary at Wooton. Around 1940, another non-denominational mission board added health to the evangelical activities of its Cutshin Bible Church near Yeaddiss. Within a decade, that program developed into Cutshin Clinic whose nursing, midwifery and limited medical services continue to reach families in the southern third of the Wooton area. A few households along Cutshin have been similarly touched by a Frontier Nursing Service center on Wolf creek that opened in 1960. And people from the entire area have used the small FNS hospital in Hyden for more than forty years, increasingly in the last ten as FNS expanded its medical staff from one to five physicians. Nevertheless, families in this part of Leslie county have tended to rely more on physicians and hospitals in Hazard than on anything in their own area or Hyden for first-line health care. As often as not, this has meant delaying medical attention until an emergency forces the issue.

That was the situation before two never fully compatible agencies joined forces in 1972 to assure a more reliable alternative. One was the Frontier Nursing Service (FNS), a non-profit organization that has brought medical and nursing services to parts of Leslie, Clay and Perry counties since 1925. FNS was ready to open a new outpost on the order of its eight other districts where family nurses and nurse-midwives work about half and half in patients' homes and in clinics at outpost centers as well as referring patients to the FNS hospital and health center in Hyden. The guiding principles of the Service are set forth in its Articles of Incorporation:

> To safeguard the lives and health of mothers and children by providing and preparing trained nurse-midwives for rural areas in Kentucky and elsewhere, where there is inadequate medical service; to give skilled care to women in child-birth; to give nursing care to the sick of both sexes and all ages; to establish, own, maintain and operate hospitals, clinics, nursing centers, and midwifery training schools for graduate nurses; to educate the rural population in the laws of health, and parents in baby hygiene and child care; to provide expert social service, to obtain medical, dental and surgical services for those who need them at a price they can afford to pay; to ameliorate economic conditions inimical to health and

> growth, and to conduct research towards that end; to do any and all other things in any way incident to, or connected with, these objects, and, in pursuit of them, to cooperate with individuals and with, organizations, whether private, state or federal; and through the fulfillment of these aims to advance the cause of health, social welfare and economic independence in rural districts with the help of their own leading citizens.

The other agent was the Mountain Comprehensive Health Corporation (MCHC), incorporated as a non-profit organization in February 1972 after several fitful formative years. The seed was planted with a 1965 grant from the Office of Economic Opportunity to the Leslie County Development Corporation, an association founded in 1962, which organized many OEO projects through the rest of the decade. The initial "Community Action Health Project for Leslie County" expanded in 1966 into the LKLP Community Action Council, an OEO agency for Leslie, Knott, Letcher and Perry counties. Working through the county health department, the program in Leslie county included, inter alia: multiphasic screening of more than 10,000 persons; provision of indicated medical, nursing, dental and social services for the indigent; health education and homemaker services; and on-the-job training of aides and outreach workers recruited from low-income families. Some of the workers and many of the ideas developed by the project sparked efforts within LKLP to create the Mountain Comprehensive Health Corporation as a vehicle to provide or contract services for poor people in the four counties. The operating rules were modified later and some services eliminated (e.g., payment of in-hospital bills) when programs originally funded through the Office of Health Affairs of OEO came under the more cautious eye of the Public Health Service in the Department of Health, Education and Welfare in 1973. But the overall goals remained those stated in the "Message to Our Patients":

> The Mountain Comprehensive Health Corporation's philosophy of health care is that the people of the four county area deserve a program of health care which is not primarily focused on acute episodic contact with health facilities and personnel. The program concern is to provide comprehensive, good quality health care services to people in the counties with emphasis on preventive care.

Before irreconciable policy differences forced a split in January 1974, FNS and MCHC worked together for nearly two years to make their shared general goal into the reality of the present MCHC Wooton Family Health Center. In this, FNS was responding to longstanding requests from families in the area. Having determined the feasibility of an outpost operation there after ruling out two other locations, FNS was committed to the undertaking by the end of 1971. Work began officially that December when two nurses (one a fully qualified nurse practitioner and midwife) began the slow process of getting acquainted up every road and hollow that a jeep could negotiate, providing services as needed and requested and holding clinics in private homes. Following the customary FNS practice of dividing the district roughly in half so that each was responsible for approximately 250 families, they made 2,341 home visits (an average of 195 per month) and saw 209 patients at clinics in the twelve months before Wooton Clinic had a home of its own.

For its part, MCHC was considering Wooton while developing plans and funds to test three alternative systems for delivering quality health care to currently underserved groups in its four county constituency. One of the systems was essentially a nursing model using nurse practitioners as the first-contact nucleus of local services and the link to networks of more specialized medical and social resources. This was the basis for negotiations that led early in 1972 to an agreement whereby MCHC (as an agent of OEO) would equip and staff a trailer clinic on the grounds of the abandoned Wooton high school. In turn, FNS would demonstrate the system of primary care nursing it had been developing since 1970 under a training and research grant from the National Center for Health Services Research and Development, but which rested on fifty years of nursing and midwifery experience among rural Appalachian families.

When the clinic finally opened in December 1972 after many frustrating delays, MCHC could promise its clientele that:

> As a participant in Mountain Comprehensive Health Corporation's program of preventive health care, you can expect: a clean modern health center; a center near your home; skilled doctors and nurses; well-trained outreach workers to help the doctors and nurses; preventive dental care; home health care if not provided by other agencies; local transportation where there is a specific medical need; confidentially kept records; people who care about you. At Mountain Comprehensive Health, we try to locate and correct health problems before they become serious. MCHC can do this only with your help. You can help by going regularly to the Health Center for physical examinations and dental check-ups. Mountain Comprehensive Health Corporation wants you to gain new knowledge to help improve your health.

With regard to eligibility, although prepayment plans of the Health Maintenance Organization type were originally favored, a fee-for-service form was ultimately adopted:

> To be a participant in the Mountain Comprehensive Health Corporation Program, an individual must be registered by MCHC. All patients will pay according to their incomes with due consideration given to those unable to meet the MCHC sliding scale payment system.

Having weathered both a factional shakeup in the central office at Hazard and the shift from OEO to HEW guidelines in the spring, Wooton Clinic was remarkably well-established and busily seeing patients at a rate of about 400 visits per month when the present study began in August 1973. By then, there was a full-time staff of fourteen plus a dentist in attendance two days a week and medical backup as needed from two FNS doctors (a family physician and a pediatrician) who made at least monthly visits to the Center. Also, except for a rapid succession of occupants in one of the two family nurse slots, staffing was stable. Six of the full-time employees, including the two nurses, resided in the Wooton area of which three were native and a fourth born elsewhere was married to a local man. The rest, all Leslie countians by birth, commuted from their home communities. Divided about equally between clinical and administrative, or organizational maintenance positions, they were the ones providing the day-to-day services detailed above.

The services are theoretically available to anyone in Leslie, Knott, Letcher and Perry counties who chooses to register with MCHC. In practice, they are most readily available to some 500 households scattered through 25 to 30 square miles of mountains lying mainly south and east of Wooton post office with a thumb poked north and west. But "square miles" is a misleading measure. It is 40 to 50 tortuous linear miles of good, bad, indifferent or impossible roadbeds winding and climbing in and out of string settlements along four main creeks and their numerous forks and branches that really count. Less than 20 are comfortable, let alone safe, at speeds as high as 35 miles per hour. Top speed on perhaps another 15 that are best done in four-wheel drive ranges from 5 to 15 miles per hour. The rest lie somewhere between, depending on one's vehicle and nerve.

Two state highways provide the basic framework, threading the easier valleys and ridges to meet in a "T" where Poundmill branch reaches Cutshin creek at Brown's Chapel. From the west, Kentucky 80 enters the area 4 miles out of Hyden after cresting a 1300' watershed before plunging 2 miles down Poundmill and through Smith Camp to the junction with Kentucky 699. The next 1¼ miles, descending to 871' at the confluence of Wooton and Cutshin creeks, pass the post office and most built up center of Wooton. Thereafter, only a handful of dwellings dot the 1½ mile ascent of Preston fork to a 1200' divide overlooking a string of houses that draw closer together near a store, church and service station in the once school-centered neighborhood at the division between Upper and Lower MacIntosh creek. Crossing the creek and skirting a piece of Bowling branch, the highway winds another crooked mile before leaving the area at the county line on its way to Hazard 12 miles beyond.

Kentucky 699 follows a similarly winding but gentler course up Cutshin creek for the 8½ miles that it forms part of the area's western boundary, rising only 100 feet from the Brown's Chapel crossroad to Cutshin post office and general store near the outlet of Maggard branch. Houses are always in view above, below or beside the road; but they huddle closest at the mouths of a half dozen tributaries which also attract country stores. And midway to Cutshin, a veritable hamlet spreads out from the large sawmill, garage, stores and Smilax post office at the foot of Polls creek, one of the longest and most populous side valleys. At Cutshin, the highway enters territory covered by Cutshin Clinic, climbing gradually for 3½ miles to 1100' at Yeaddiss, then more sharply through 2½ miles of almost uninhabited mountains to nearly 1300' at Big Rock. From there, it takes a 2½ mile precipitous twist up Low Gap branch and over the 1700' top of Leslie county into Leatherwood and ultimately 30 miles farther to Hazard.

Other macadamized surfaces start out bravely along Lower Cutshin (3¼ miles long), Upper Wooton (5½ miles), and Lower MacIntosh (3 miles) only to yield within the first mile or two to gravel, dirt and eventually boulders or mud. The roads up Polls creek (5 miles) and Upper MacIntosh (1 3/4 miles) never pretend to more than dirt or gravel and dwindle to pockmarked traces made worse on Polls creek by strip mining operations. The creek roads, in combination with the two thoroughfares and about twenty far less reliable feeders, lace more than thirty identifiable neighborhoods into a net uniting headwaters with larger streams and pulling all toward a growing stake in Wooton services.

Moving downstream on each creek, the principal forks and branches pulled in are Maggard, Beech Bottom, Levi Lewis, Larkin Lewis, Saw, Poundmill, Meetinghouse, another Maggard and Flackey on Cutshin; Stratton, Engle, White Oak, Bear, Lick, Dicks and Collins on Polls creek, which itself flows through Upper, Middle and Lower divisions before joining Cutshin between Larkin Lewis and Saw branches; Laurel, Lick, Polecat, Big Two, Cane, Good, Browning (or Second Fork), Camp, Bailey, Caudill, Looney, Leadmine and Preston on Wooton; and Bowling, Big Peavine and Little Peavine on MacIntosh, which in turn meets Cutshin 2½ usually impassable miles below Flackey branch to complete an amoebalike boundary around the skein of roads connecting the dispersed segments of the community. Up to a quarter of the forks and branches are no longer inhabited, and families on several others are dying out or moving to more convenient locations. On the other hand, one of the most severely isolated sections - four or five converging hollows around Frew post office on Polecat branch at the tip of Upper Wooton - still had 29 households in 1973; and most families continue to identify with a particular creek or home neighborhood despite the loss of individual members to other neighborhoods and areas in every recent generation. Nor are there greatly differing styles and levels of living between remote and less remote settlements beyond a tendency for some of the poorest families to cling to the heads of hollows. There is less new construction, and more deteriorating houses toward the tapering ends of the worst roads; but every creek has its share of new and recently refurbished homes amid earlier one story frame houses and rambling two story structures of wood and occasionally stone. Especially popular of late, trailer homes of all sizes perch singly on improbable slopes or gather sociably around parental homesteads and near crossroads commerce. Whatever their size or age, dwellings may vary in condition from sound to dilapidated, from trimly neat to grossly neglected; and the same is true of the 20 general stores and 11 churches.

In its parts and as a whole, the community ranges from comfortable well-being to defeated poverty in an ever changing mixture of modern with traditional evidences of middle and working class life. The economic base for this is suggested by income and occupation statistics from the 1970 Census in Enumeration District - 05 (ED-05) of Leslie county. The district includes approximately 75% (a bit over 400) of the families in the Wooton area plus some 300 households in an adjacent portion of the Upper Cutshin watershed; the other 25% of Wooton families live across the road on Cutshin and up Poundmill in Enumeration District - 06. Since there is little difference between the two census tracts and both are quite homogeneous, the figures for ED-05 presented in Tables 1-3 are indicative of conditions in the Wooton area generally.

Table 1 reveals that 53.9% of the households in ED-05 were below the poverty level of $3,968 designated by the Social Security Administration on the basis of U.S. Department of Agriculture estimates of the minimum cost of its Economy Food Plan (times roughly 3 1/3 for other basic needs) to a family of four living in a Southern state. The USDA acknowledges that this is not a reasonable measure of actual nutritional needs and recommends use of a formula based on its 25% costlier Low-cost Food Plan. Using the latter plan, 66.9% of the families in the district fell short of the $4,963 required in 1969 for a four-member household in the South to maintain an adequate diet while meeting other cash needs. The median income in ED-05 at that time was only $3,772 compared with $7,439 in Kentucky and $9,586 in the nation. Moreover, fewer than ten percent (7.4%) had incomes over $10,000 while 37.1% received less than $3,000. The next two tables help to explain the income situation.

Table 2 highlights the restricted nature of the economic environment in which coal mining overshadows everything else. The mining involves a considerable variety of trades and graded positions in both surface and underground operations, but jobs increase or decrease entirely in terms of a single notoriously erratic and life-stifling industry. 54.7% of the employment in ED-05 in 1970 was in the mines, and the direction since has been toward even greater

TABLE 1. FAMILY INCOME LEVELS IN ENUMERATION DISTRICT-05, LESLIE COUNTY, KENTUCKY, 1969

Income per Annum	Families (N=690)	
	No.	%
$0 - 999	48	7.0
$1,000 - 1,999	127	18.4
$2,000 - 2,999	81	11.7
$3,000 - 3,999	116 (362)*	16.8 (53.9)*
$4,000 - 4,999	90 (452)**	13.0 (66.9)**
$5,000 - 5,999	49	7.1
$6,000 - 6,999	72	10.4
$7,000 - 7,999	33	4.8
$8,000 - 8,999	14	2.0
$9,000 - 9,999	9	1.3
$10,000 - 11,999	34	4.9
$12,000 - 14,999	9	1.3
$15,000 - 24,999	0	0
$25,000 +	8	1.2

* Below poverty level as defined by the Social Security Administration, using the Department of Agriculture's Economy Food Plan.

** Below poverty level, using the Department of Agriculture's Low-Cost Food Plan.

TABLE 2. EMPLOYED PERSONS BY INDUSTRY IN ENUMERATION DISTRICT-05, LESLIE COUNTY, KENTUCKY, 1970

Industry	Employed Persons (N=536)	
	No.	%
Mining	293	54.7
Professional and related services	42	7.8
Construction	39	7.3
Wholesale and retail trade	33	6.2
Manufacturing	31	5.8
Public Administration	21	3.9
Transportation	16	3.0
Agriculture	10	1.9
Personal services	9	1.7
Repair services	5	.9
Industry not reported	37	6.9

dominance. The next largest category, which includes teaching among other professions and related services, occupied only 7.4% of all employed persons, followed by construction work (7.3%), wholesale and retail trade (6.2%), manufacturing (5.8%) and a sprinkling in public administration (3.9%), transportation (3%), personal services (1.7%) and repair services (.9%). Less than two percent (1.9%) engaged in commercial farming which is hardly profitable given the terrain and distance to markets.

Though the figures are not separated in the table, women held a majority (57.1%) of the professional and administrative positions and performed all the clerical and domestic service work but were represented only marginally (3.7%) among operatives and foremen (who here are chiefly miners). In all, they comprised 15% of the total labor force compared to the 39% showing of women nationally in 1970. To a large extent, this simply reflects the local dearth of suitable jobs; but families in this part of rural Appalachia are also relatively untouched as yet by the national trend to full-time employment of women outside the home with its implied de-emphasis of childbearing and the personal mothering of one's own children.

With 536 employed persons distributed among 690 families, clearly at least one-fifth of the households in ED-05 had no gainfully employed member at the time of the 1970 Census. Table 3, which reports all sources of income, suggests that in fact a minimum of 28% and probably more found themselves in that position. 62% of the families received wages or salaries, predominantly

TABLE 3. INCOME SOURCES OF FAMILIES IN ENUMERATION DISTRICT-05, LESLIE COUNTY, KENTUCKY, 1970

Source	Families (N=690)[*]	
	No.	%
Wages and salary	428	62.0
Non-farm self-employment	54	7.8
Farm self-employment	15	2.2
Social Security	200	29.0
Public Assistance	151	21.9
All other	58	8.4

[*] Percentages total more than 100 because of multiple income sources in some families.

from mining; and another 10% were self-employed. Statistics not shown in the table indicate that although slightly more than 60% of the district's labor force worked a full year in 1969, about 6% did not work at all and 5.5% worked less than six months. Also relevant to income, 23.8% of the adults aged 16-64 were handicapped or disabled compared to 16.4% for other whites nationally (the figure for non-whites was 24.3%). Social Security benefits for disabled and retired workers and their survivors assisted 29% of the families, but Public Assistance was the principal recourse for fully one-fifth (21.9%).

The first three tables refer to the enumeration district that includes most of the Wooton area. Except for minor variations from one to another of the county's eight census districts, the economic conditions in ED-05were representative of Leslie county as a whole in 1970 and have changed little since. They form a backdrop, along with the foregoing description of the community and brief history of its MCHC clinic, for a closer look at the medical beliefs and experiences of actual and potential clients of the Wooton Family Health Center in 1973. For that, the household head and/or spouse in 51 (9.8%) of the 521 occupied houses in the core service area were interviewed, using a specially designed 22-page "Health Care Questionnaire and Interview Guide" that contained nearly 160 separate items and took from thirty minutes to several hours to administer. Its preamble states the broad purpose:

> Dr. Marion Pearsall, who teaches at the University of Kentucky Medical Center and who is also helping the Frontier Nursing Service evaluate their program for training Family Nurse Practitioners, is making a Survey of health care problems in this part of Leslie County. It is only by knowing how people feel about their health problems and the kind of medical and nursing services they are getting that we can do a better job of training doctors and nurses. We would appreciate it very much if you will take the hour or so necessary to answer our questions. Your answers will be kept confidential, and we won't put your name on the questionnaire if you don't want us to. But by getting the ideas of a lot of people about their health problems, we can write a general report that will be helpful to young doctors and nurses who are interested in working in rural areas like Leslie County.

It is of interest that only one person refused to answer at all and only two requested that their name not be written on the face sheet. A third quite ill person finished only a third of the questions before tiring. In every instance, although respondents were given a copy of the questionnaire to read and follow, the questions were asked and recorded by the interviewer - or more often with one interviewer asking the questions and the other writing the answers.

Table 4 shows the distribution of the 51 households in relation to others in the several geographic divisions. The selection was more purposive than random. It was based on two months of observations and conversations at the Center, home visits with nurses and other clinic personnel and without them, and on a general knowledge of the county and its health services dating from an earlier period of research in 1959-60 plus recent acquaintanceship with the Family Nurse Practitioner training program of the Frontier Nursing Service since its inception in 1969-70. The intent was to include a range of circumstances and experiences that might affect the acceptance and utilization of nurse practitioners in the delivery of primary health care services. An attempt was made, therefore, to choose in each major portion of the community some families known to be modern and progressive in their ways and others with a more old-fashioned or traditional outlook and to elicit opinions both from families in excellent health and others with multiple experience of acute or chronic ill health.

An unintended and regrettable bias is the probable underrepresentation of families for whom distance and road conditions are especially critical in decisions to seek or forego medical assistance. This resulted when the 68 (13.1%) households in six of the most isolated sections were by-passed in order to complete a larger total number of questionnaires in the time available - two a day was about the average. On the other hand, at least 10% of those who did participate lived at the 4-wheel drive or walking edge of their neighborhoods, some of which (e.g., on Upper Polls creek, Bear branch and Second fork) are every bit as distant and difficult of access as, say, Levi Lewis and Bailey branches where no one was interviewed. Actually, the degree of isolation seemed to make little difference in the patterns of belief and practice ✓ that emerged, suggesting again that there is as much variation within as between neighborhoods.

Finally, all fourteen full-time members of the Family Health Center staff were interviewed with the same questionnaire. The dentist, who came over from central Kentucky two days a week, was interviewed informally and observed for many hours in clinic; but there was no spare time for lengthy questioning. Six of the staff are also included in the community sample, four in family households and the two nurses as a separate household. In the latter case, one nurse had been a resident and active in church and other community affairs for nearly two years; the other was there only temporarily for a couple months. The responses of the entire staff are compared with those of the community throughout this report with the object of noting similarities and differences that may have special relevance for understanding the acceptance and use of professional services by local populations. Here let me acknowledge a bias that may creep into the report by saying that Wooton Clinic had the friendliest, most neighborly atmosphere I have seen in almost twenty years of observing health care settings. The professional quality was high without loss of the personal quality.

Table 5 compares the clinic staff and the sample of Wooton residents by marital status, age, education and length of residence. The most striking fact about the great majority in both groups is their lifelong identification with Leslie county. 74.4% (42) of the residents and 64.3% (9) of the staff were born in Leslie county. If neighboring counties (usually Perry) are added, the numbers become 50 (86.2%) and 11 (78.6%). Half (29) of the residents and 35.7% (5) of the staff had spent their entire life there, though as many others had resided elsewhere for varying periods. In all, community residents had lived an average of 40.2 years in the county, but only 12 years in their present house. The range (1 to 82 years if the anomalous temporary nurse is eliminated) of course indicates an ample number who were not such old-timers, including 6 (10.3%) besides the two nurses who were born in other states. Mainly because they averaged 13.3 years younger, staff members had lived in the county fewer years; but the average was 26.3 years (10 in their present house), with a range from one month to 53 years. Through such prolonged residence in this sparsely populated county (11,623 persons in 1970), many had known or known about each others' families for many years even if they were not acquainted personally. Only the outside professionals began as complete strangers.

A striking difference between the two groups is the age differential mentioned above. By itself, age is no particular barrier in a society where the ages mingle freely on most occasions and where both small children and the elderly receive special attention. But some of its corollaries make for a degree of social distance between clinic and clientele. The staff members, with an average age of 35.1 years and a range from 23 to 53 were at the height of their productive years. More of the residents, whose average age was 48.4 years with an upper limit of 82, were near the end or beyond their most profitable years. Age helps to explain, too, the presence of 6(10.3%) widowed persons in the community sample and none on the staff as well as the higher proportion of single persons on the latter. More importantly, age decreed an educational disadvantage for some of the older residents with no schooling and others who had attended now defunct and never adequate one-teacher schools; the average was an elementary education of 8.7 years. No staff member had fewer than 7 years of schooling and several had up to 4 years of college credits for an average of 12 years, which is approximately that for the nation.

Age and education together help to explain the differential employment status of the two groups. Staff members were by definition full-time employees of MCHC, 8 of them in professional and paraprofessional positions, 4 in administrative and related

TABLE 6. EMPLOYMENT STATUS OF THE MAIN EARNER IN 50 WOOTON HOUSEHOLDS

Employment Status	Households No.	Households %
Mining	16	32.0
Professional and related	5	10.0
Retail trade	4	8.0
Transportation	1	2.0
Subtotal	(26)	(52.0)
Retired	11	22.0
Disabled	6	12.0
Widow	3	6.0
Public Assistance	4	8.0
Subtotal	(24)	(48.0)
	N= 50	100.0

TABLE 5 -CONT.

	Wooton Residents (N=58)*	Clinic Staff (N=14)
Years In Leslie County		
Entire life	29 (50%)	5(35.7%)
Range	1 month-82 years	1 month-53 years
Average	40.2	26.3
Years in Present House		
Range	1 month-52 years	1 month-25 years
Average	12.1	10

*Includes 6 husband and wife interviews.

TABLE 5. COMPARISON OF WOOTON RESIDENTS AND CLINIC STAFF BY MARITAL STATUS, AGE, EDUCATION AND LENGTH OF RESIDENCE

	Wooton Residents (N=58)*	Clinic Staff (N=14)
Marital Status		
Single	5 (8.6%)	4 (28.6%)
Married	44 (75.9%)	9 (64.3%)
Widowed	6 (10.3%)	0
Divorced/separated	3 (5.2%)	1 (7.1%)
Age		
Range	17-82	23-53
Average	48.4	35.1
Years of School		
Range	0-17	7-17
Average	8.7	12
Birthplace		
Leslie county	42 (72.4%)	9 (64.3%)
Nearby counties	8 (13.8%)	2 (14.3%)
Other states	8 (13.8%)	3 (21.6%)

TABLE 4. DISTRIBUTION WITHIN THE WOOTON AREA OF OCCUPIED HOUSES AND HOUSEHOLDS INTERVIEWED, FALL 1973

	Houses		Households Interviewed		
Locality	No.	%	No.	% of Locality	% of Sample
Poundmill, Smith Camp	59	11.3	8	13.6	15.7
Lower Cutshin	31	5.9	3	9.7	5.9
Meetinghouse	7	1.3	0		
Upper Cutshin	139	26.7	6	4.3	11.8
Beech Bottom	4	.8	0		
Levi Lewis	8	1.5	0		
Polls Creek	66	12.6	12	18.2	23.5
Bear	5	1.0	2	40.0	3.9
Wooton, Upper Wooton	98	18.8	14	14.3	27.5
Frew	29	5.5	0		
Browning (2nd Fork)	23	4.4	2	8.7	3.9
Bailey	15	2.9	0		
Upper, Lower MacIntosh	32	6.1	4	12.5	7.8
Bowling	5	1.0	0		
Totals	521	99.8	51	9.8	100.0

office positions and one each in transportation and maintenance. The situation was very different in the community group, as seen in Table 6. Although 86% (43) of the principal earners in the 50 family households had worked most of their lives (often in a succession of trades), only 52%(26) were currently in the active labor market in the occupations and proportions one might expect - mining (32%), professional and related services (10%), retail trade (8%) and transport (2%). Mining also accounted for all but one of the 6 (12%) disabled breadwinners and most of the 11 (22%) retired workers. In 80% (40) of the households women were not employed outside the home; but in 4 (8%) they were the main provider and in another 4 (8%) they contributed through part-time work. While no direct question was asked about other than occupational sources of income, respondents in 4 (8%) households reported their total dependence upon Public Assistance and several others were known to be receiving such help for a probable total of 12 to 14%. In contrast to the clinic staff, then, up to 48% (24) of the local families interviewed subsisted on the meagerest of retirement, disability or public payments.

Further differences associated with age and educational level appear in Table 7 which nevertheless suggests an underlying similarity in household and family composition. Both groups, for example, had an average of 4.1 persons per household, a figure that characterized Americans generally in 1930 but that had declined nationally to 3.1 by 1972. And with from 1 to 10 members compared to 2 to 6 for the staff, the residents had an even larger median household of 5 persons. The residents also more nearly exemplified an earlier family form in that 72% (36) of them had had 4 or more children though only 43.3% of American families in general were that large in 1972. Individual women had borne up to 13 children for an average of 5.2 and a grand total of 265 offspring in the 50 families. The average of 2.9 children (from 1 to 7 and a total of 35) in the 12 families represented by the staff was much closer to the national norm in 1972 of 2.3 children ever born to married women between the ages of 15 and 44.

Despite their relatively older age and presumably higher percentage of completed families, 33 (66.7%) of the residents had from 1 to 7 (average 2.8) children under age 18 residing at home. Although proportionately more staff families (9, or 75%) had children under 18 in their homes, the average was only 1.8 with a range from 1 to 4. Additionally, between a fifth and one-fourth of the families in both groups had from 1 to 3 older children at home. More significantly, a majority of all adult children were close at hand. Of 108 children in the resident group who had left home, 47 (43.5%) were still in Leslie county or adjacent Perry county where many Wooton families have kinfolk. Another 12 (11.1%) lived elsewhere in Kentucky, leaving 49 (45.4%) who had wandered farther afield. Similarly, 5 of the 10 children no longer living with staff families were in the immediate vicinity and 2 others were at least in the state. Nor were those in other states necessarily out of touch since their location was far from random. In the search for employment that takes up to half of every new generation out of the poorest Appalachian counties, they had followed a long established route of migration and continuing communication between eastern Kentucky and a selected few industrial centers, principally in the neighboring states of Ohio and Indiana (13.1% of the residents' children and all 3 children who had left the state from staff families), secondarily in Michigan and North Carolina (4.7%), and more individualistically in scattered locations from the District of Columbia to California (4.2%). Put differently, all of the out-of-state migrants from staff families and three-fourths of those from resident families had relocated in areas with flourishing "little Kentuckies."

In addition to listing the ages and current addresses of all living children, respondents were asked, "Have you lost any children?" The answers point up the greater risk to the generally poorer, older and larger local families who lacked adequate health services at crucial periods in their lives. Though 2 (16.7%) staff members reported 3 miscarriages and an infant death, this is small compared to the 28 (56%) resident families with from 1 to 6 (51 in all) deceased children, all but two of whom died before the age of 21. A majority (27, or 52.1%) involved miscarriages and premature or still births, and it is indicative of the value placed on new life that nearly everyone remembered even early spontaneous abortions as potential members of the family. Of the 24 (47.1%)

later deaths, 14 (58.3%) occurred in the first two years of life and 4 (16.7%) each fell between the ages of 3 and 10 and 11 and 20. Three (12.5%) were accidental from drowning, a gunshot wound and a car wreck. No cause was given for eight of the remaining 87.5% (21) and most others were described in non-medical terms although pneumonia, flu, leukemia and "bad strep throat" were mentioned along with less explicit fevers, sudden and mysterious attacks (e.g., "He was took in the head and died in three days") and one estranged conviction that "They killed her at Miners Hospital, that's what they did; but they put 'gastroenteritis' on her chart."

The experiences summarized in Table 7 and discussed above cover a span of 82 years in which Leslie county evolved from a remote enclave ringed by other almost equally isolated mountain counties to a region increasingly open to modern influences and services. The next three tables report the answers to two questions that permitted respondents to compare the present situation with conditions at an earlier time that virtually all were old enough to recall. The first asked, "In general, would you say that people's chances of having good health are better nowadays, worse, or about the same as they were 15 years ago (around 1959-60)?" The second requested an explanation, "Why do you think that is so?"

As Table 8 demonstrates, the great majority in both groups but especially residents of the Wooton area sensed an amelioration of health conditions in the last decade and a half. 78.8% (41) of the residents declared that people had a better chance of being healthy

TABLE 7. HOUSEHOLD AND FAMILY COMPOSITION OF WOOTON RESIDENTS AND CLINIC STAFF

	Wooton Residents	Clinic Staff
Household Composition		
No. of Households	51	13
No. of Persons	206	53
Persons/household		
Range	1-10	2-6
Average	4.1	4.1
Family Composition		
No. of family units	50	12*
No. of children ever	265	35
Range	0-13	1-7
Average	5.2	2.9
Children under 18 at home		
No. of families	33 (66.7%)	9 (75%)
No. of children	91	16
Range	1-7	1-4
Average	2.8	1.8

Table 7-Cont.

Children over 18 at home		
No. of families	9(18%)	3(25%)
No. of children	16	5
Range	1-3	1-3
Average	1.8	1.7
Children living elsewhere		
No. of families	30(60%)	6(50%)
No. of children	106	10
Range	1-9	1-3
Average	3.5	1.7
Residence of children		
Living at home	107 (50%)	21(67.7%)
Elsewhere in Leslie and Perry counties	47 (21.9%)	5(16.1%)
Other Kentucky locations	12 (5.6%)	2(6.5%)
Other states and abroad	49 (22.9%)	3(9.7%)
Ohio	15 (7%)	1(3.2%)
Indiana	13 (6.1%)	2(6.5%)
Michigan	6 (2.8%)	
North Carolina	4 (1.9%)	
Other states and D.C.	9 (4.2%)	
Overseas	1 (.5%)	

Table 7-Cont.

Deceased children		
No. of families	28 (56%)	2 (16.7%)
No. of children	51	4
Range	1-6	1-3
Average	1.8	2

*This figure excludes the 2 single nurses who shared an apartment but includes the families of the 2 single staff members still living at home.

TABLE 8. ESTIMATED CHANGE IN THE CHANCES FOR GOOD HEALTH FROM 1959-60 TO 1973

Conditions in 1973	Wooton Residents	Clinic Staff
Better	41 (78.8%)	9 (64.3%)
Worse	6 (11.5%)	1 (7.1%)
About the same	3 (5.8%)	4 (28.6%)
Don't know	2 (3.8%)	0
	N=52 (99.9%)	N=14 (99%)

TABLE 8. ESTIMATED CHANGE IN THE CHANCES FOR GOOD HEALTH FROM 1959-60 TO 1973

Conditions in 1973	Wooton Residents	Clinic Staff
Better	41 (78.8%)	9 (64.3%)
Worse	6 (11.5%)	1 (7.1%)
About the same	3 (5.8%)	4 (28.6%)
Don't know	2 (3.8%)	0
	N=52 (99.9%)	N=14 (99%)

in 1973 than at the end of the 1950's; only 6 (11.5%) considered the situation worse, and 3 (5.8%) thought things were about the same. Staff members were slightly less sanguine. While 9 (64.3%) of them thought conditions had improved, 4 (28.6%) considered tham about the same and one believed they had worsened.

A somewhat opposite trend appears in Table 9 which reflects a distinction many respondents made between health services and health as a state of personal well-being. Three-fourths (39) of the residents and 8 (57.1%) staff members rated conditons better today when the referent was health services, but only 10 (19.2%) residents and one staff member were that optimistic about an individual's likelihood of staying well. And on this score residents were the more pessimistic with fully half (26) good believing that the chances for health have decreased compared to only 2 (14.3%) staff members who felt that way.

The same distinction is seen in Table 10 which summarizes respondents' explanations for the changes reported in Tables 8 and 9. By and large, people who saw improvement offered reasons related to the quantity, quality and availability of medical services; but most of the reasons given for deteriorating health related to the impact of present-day life on individuals. With regard to the former, residents and staff were in accord about the salutary effects of more and better medical care (55.8% of the residents; 57.1% of the staff), better transportation (21.2% and 14.3%), better education (11.5% and 14.3%), and better economic conditions

TABLE 9. CHANGES IN INDIVIDUAL HEALTH COMPARED WITH CHANGES IN HEALTH SERVICES FROM 1959-60 TO 1973

	Conditions in 1973*			
	Better	Worse	Same	Totals
Individual Health				
Residents	10 (19.2%)	26 (50%)	4 (7.7%)	40 (76.9%)
Staff	1 (7.1%)	2 (14.3%)	3 (21.6%)	6 (42.9%)
Health Services				
Residents	39 (75%)	5 (9.6%)	0	44 (84.6%)
Staff	8 (57.1%)	0	0	8 (57.1%)

*Percentages are based on a total N of 52 residents and 14 staff members, though not all chose to make a distinction between individual health and health services.

TABLE 10. REASONS GIVEN FOR CHANGES IN HEALTH
CONDITIONS FROM 1959-60 TO 1973

Reasons	Wooton Residents (N=52)*	Clinic Staff (N=14)*
Better health in 1973		
More, better services	29(55.8%)	8(57.1%)
Better transportation	11(21.2%)	2(14.3%)
Better education	6(11.5%)	2(14.3%)
Better economically	4(7.7%)	3(21.6%)
Worse health in 1973		
More sickness	13 (25%)	1 (7.1%)
Poorer foods	12 (23.1%)	0
Too much medicine	5 (9.6%)	0
Poor personal habits	3 (5.8%)	0
High medical costs	2 (3.8%)	1 (7.1%)
Doctors inaccessible	2 (3.8%)	1 (7.1%)
Old medicines better	1 (1.9%)	0

* Percentages total more than 100 because some gave multiple reasons.

(7.7% and 21.6%). With regard to the latter, however, staff members were largely silent, making only 3 comments; it was the residents who lamented what they viewed as deleterious side-effects of modernity. In 38 negative and 50 positive comments, the residents seemed almost as pessimistic about individual life chances as they were optimistic about the benefits of modern medicine. Two plaints were foremost: an increase in the amount of sickness perceived by 13 (25%) persons; and the belief of 12 (23.1%) that food quality and dietary practices have degenerated. Other explanations for declining health levels were less widespread: too much reliance on doctors and drugs (9.6%); unwholesome living (5.8%); high medical costs (3.8%); the unconcern and inaccessibility of doctors (3.8%); and one lone insistence that "The old medicine was better and it didn't take so much trouble."

The table can only summarize. The wealth of experience and feeling in people's evaluation of a changing world is best conveyed in their own words. While some answers were either enthusiastically positive or gloomily negative, more were as mixed in tone as the following:

> 1. People have come a long way in medicine. There are good roads and automobiles. But more people are ailing than in my growing up time. It shows when you go to see the

doctor.

2. Things have gotten better but more expensive. People are dying of more diseases now than 15 years ago. Transportation is better because they send trucks out for us if we can't get rides to the clinic.

3. There are better doctors and they know more, but no one used to be sick much. People lived far apart and didn't spread things. Things used to kill people; now they just hang on.

4. There's more money, better medicine and better opportunity to eat better. But people's health is worse. They don't eat proper food. Two-thirds of them don't know how to shop. They need education in this field. I know because I run a store.

5. People have better chances but their health seems to be worse. When I was growing up you never heard of heart attacks. I've read they may be because of frozen food. Food tasted better back then hanging in the smokehouse. We didn't have deep freezes.

Overall, there was more praise than criticism of the contemporary scene; but few statements were as completely optimistic as the following:

1. Chances are much better. We're getting more knowledge of medical uses and things that really can be done. There are better roads to get you there. There are more doctors, especially specialists and better hospitals.
2. Everything is better - transportation and more nurses and the Wooton clinic. People's health is better, too. They just don't know about the trouble before.
3. It's better with new drugs, and

> doctors and nurses around to
> give you advice. If you follow
> their advice, you'll get better.
> People's health is better because
> they are more educated. They
> know how to take care of
> themselves.

Despite the previously noted misgivings of many about the mixed blessings of modern life, very few statements were as unrelievedly bleak as the following:

> Medical expenses are
> higher than 15 years ago. It is
> harder to get in to see a doctor.
> People can usually get to the
> office, but they have to wait.
> Most people don't go to the
> doctor as often as they should.
> They have to pay for food and
> utilities first. Then, maybe,
> they can think about their health.

Better roads and cars figured prominently in descriptions of changes that have brought citizens of the Wooton area closer to good health over the past fifteen years. Transportation was also one of several measures of accessibility that were incorporated into more direct questions. People were asked if they had a driver's license and whether anyone in their household owned a car or other motor vehicle. This was followed by the query, "Is the (car/truck) always available, or are there times when you couldn't get a ride to wherever you had to go?" And finally, "What would you do in an emergency if there wasn't a car or other motor vehicle available at your house?" Table 11 presents the answers.

The table shows residents as a group to be considerably more cut off from centralized services than the staff. Less than half (25, or 43.1%) had a driver's license compared to 92.3% (13) of the staff. While the lack of a valid license did not deter some from driving about on back roads, they rarely courted arrest by venturing onto a main highway. Fewer residents, too, had their own transportation. Although every staff household owned one or more cars or trucks, 15 (28.8%) local households had neither. And among those who did have transportation, residents were more likely to be left without a vehicle during the workday. Consequently, only slightly more than half (27, or 51.9%) of the residents but 85.7% (12) of the staff thought their families could always get themselves wherever they needed to go.

At the same time, no one had much difficulty in naming alternatives should transport not be immediately available. The sources named, however, did not entirely coincide in the two groups. Neighbors were the first choice of both staff and residents by 42.9% (6) and 34.6% (18) respectively. Relatives, who were not cited by the staff, were next on the residents' list with 15(28.8%)

TABLE 11. ACCESS TO TRANSPORTATION BY WOOTON RESIDENTS AND CLINIC STAFF

	Wooton Residents	Clinic Staff
Valid Driver's License		
Yes	25(43.1%)	13 (92.8%)
No	33(56.9%)	1 (7.7%)
	N= 58 (100%)	N= 14 (100.5%)
Family Vehicle	37 (71.2%)	14 (100%)
Always available	25 (48.1%)	12(85.7%)
Sometimes unavailable	12 (23.1%)	2 (14.3%)
No vehicle	15 (28.8%)	0
	N= 52 (100%)	N = 14 (100%)
Emergency Transportation	(N=52)*	(N=14)*
Neighbor	18 (34.6%)	6 (42.9%)
Relative	15 (28.8%)	0
Wooton Clinic	15 (28.8%)	2 (14.3%)
Ambulance	4 (7.7%)	5 (35.7%)
Taxi	1 (1.9%)	2 (14.3%)
Service Station	1 (1.9%)	1 (7.1%)
Employee	1 (1.9%)	0
Doctor	1 (1.9%)	0
Minister	0	1 (7.1%)

*Percentages total more than 100 because some named more than one source of emergency transportation.

mentions. And in its brief period of operation, the Wooton Clinic had become equally recognized as a possible transportation agent by 15 (28.8%) residents. The comparable second choice of staff members was an ambulance, perhaps in part because of their greater clinical knowledge but mainly because more of them lived closer to and knew the funeral home director of the nearest ambulance service in Hyden. Only 4 (7.7%) residents referred to ambulances, and one of them would "call my nephew who drives an ambulance in Hazard." Indeed, the dominant impression from residents' remarks is that of an informal and thoroughly workable network of relatives and neighbors who frequently are one and the same. Examples included: 1) son or neighbor; 2) borrow a car from mother-in-law next door; 3) hire someone, usually a neighbor; 4) sister about a mile away; 5) son or daughter who live on either side; 6) son or brother right near; 7) brother-in-law across the road; 8)"just holler to the neighbors for help."

Similarly informal arrangements were reported when people were asked: "Do you have a telephone?"; and if not, "Where and how far away is the nearest phone you could use?" As Table 12 indicates, there were fewer telephones than motor vehicles in both groups since getting places is more essential than calling most of the time. In fact, estimates based on a rough census of occupied houses and an attempt to identify local listings from the county directory suggested that only about 20% of the 521 households in the Wooton area had telephones, though 50% of those included in

TABLE 12. ACCESS TO TELEPHONES BY WOOTON RESIDENTS AND CLINIC STAFF

	Wooton Residents	Clinic Staff
Telephone in the Home	(N=52)	(N=14)
Yes	26 (50%)	10 (71.4%)
No	26 (50%)	4 (28.5%)
No Home Telephone	(N-26)*	(N=4)*
Owner of available phone		
Relative	11 (42.3%)	1 (25%)
Other neighbor	10 (38.5%)	3 (75%)
Store, service station	7 (26.9%)	0
Distance to phone		
"Next door"	14 (53.8%)	0
Other nearby location	8 (30.8%)	4 (100%)
¼ to 1 mile	4 (15.4%)	0

* Percentages total more than 100 because some listed more than one available telephone.

the survey did - a discrepancy occasioned by underrepresentation of the most far-flung hollows. This was still well below the 70% figure for staff households.

The 4(28.5%) staff families who lacked telephones had access to those of neighbors or nearby relatives. The same was true for 11 (42.3%) of the 26(50%) residents without phones who could use a relative's and 10 (38.5%) who went to other neighbors, while 7 (26.9%) were convenient to stores or service stations that are an important part of the area's communications system in many other ways also. By these several means, 94.6% (22) of the phoneless residents were within a quarter of a mile of a telephone and none was farther than one mile, though distances were usually stated less precisely (e.g., "next door," which could mean a few steps or a few hundred yards; "the second/third house down/up the road"; "down to the main road"; or "the gas station next door during the day and grandfather's up on the hill at night").

Telephones and motor vehicles are countable objects. The other two measures of relative isolation from emergency care called for more subjective estimates. The first gave respondents three options ("a whole lot," "a little" and "no trouble at all") to the question, "How much trouble would you have trying to get a doctor to come to your home?" The question was then repeated substituting "nurse" for "doctor." Table 13 records the answers to the first query and summarizes additional comments about doctors by 36(69.2%)

residents and 11 (78.6%) staff members. Table 14 does the same for the question about nurses to which 45 (86.5%) residents and 6 (42.9%) staff members appended comments.

As a group, the residents clearly were more convinced than the clinic staff that it would be extremely difficult to get a doctor to their homes, 65.4% (34) to 21.6% (3). Conversely, proportionately more staff members thought there would be no trouble, 21.6% (3) to 13.5% (7). At the same time, half of the staff registered uncertainty ("Don't know") and 6 (54.5%) of them who ventured further comment stated that doctors hardly ever make house calls any more. This was the gist, too, in 38.9% (14) of the comments offered by residents. About a third of those qualifying their answers in both groups said they had never personally tried to call a doctor. At least 4 of the residents had tried and succeeded, and 3 others felt sure one would come in a real emergency; but there was considerable disagreement over the current policies of particular physicians. Most of the supplementary statements recognized as a more or less insurmountable fact of modern life that the onus was on the patient to get himself to a doctor. Yet no one chose to note the possible advantages of being treated in a properly equipped office or clinic. The following examples suggest the general tone:

> 1. I've never had to call one. But it's so hard to see them in the hospital it would be harder to get one to the house.

2. I wouldn't call one unless it was a real emergency. Then I'd call Dr. _____ . He's not supposed to come, but I think he would if he knew it was serious.
3. It would take awhile for the ones that would go out. Usually you have to take them [the sick person] to a hospital.
4. We got Dr. _____ a few years back, but now we'd probably have trouble. Doctors don't really come out any more.
5. I had a whole lot of trouble getting Dr. _____. He said he was trying to get away from house calls and why didn't I take her [a daughter] to Hyden Hospital. I said I would, and I've never been back to Dr. _____. I hadn't called the hospital first because I knew it wasn't their policy to make home visits. Dr. ____ had

> been our family doctor for
> years; but now he's too
> independent. He's not as
> dedicated as he used to be.
> Now I always go to Hyden.

Whatever their rationale for refusing, the few potentially available physicians could not, either now or in the past, respond to all calls from the sprawling mountainous environs of their town-centered practices. But many Leslie countians have an alternative in FNS and other nurses who to a significant degree fit a cherished image of the kindly country doctor and dedicated general practitioner of an earlier era. It is therefore not surprising that a resounding 96.1% (50) of the Wooton residents and 71.4% (10) of the clinic staff were confident they would have little or no trouble getting a nurse to come to their house. And as the following examples demonstrate, supplemental remarks added only minor pragmatic reservations: 1) "One time I called and the nurse wasn't there"; 2) "They come if you explain the trouble"; 3) "She would come as soon as possible if she didn't get an emergency"; 4) "They tell us when they can come and get here as fast as they can"; 5) "If it's serious, they come right on"; 6) "Before Wooton Clinic opened we used Hyden or Wendover and it took longer to get out here." Consistent with that confidence, the residents especially turned habitually and in greater numbers to nurses than to doctors for home visits. In fact, twice as many named nurses or nursing centers they had

TABLE 14. TROUBLE GETTING NURSES TO MAKE HOUSE CALLS

AS PERCEIVED BY WOOTON RESIDENTS AND CLINIC STAFF

	Wooton Residents	Clinic Staff
Amount of trouble		
Whole lot	0	1 (7.1%)
Little	1 (1.9%)	1 (7.1%)
None	49 (94.2%)	9 (64.3%)
Don't know	2 (3.8%)	3 (21.6%)
	N = 52 (99.9%)	N= 14 (100.1%)
Additional Comments	(N=45)*	(N=6)*
Soon as possible if needed	9 (20%)	2 (33.3%)
Easier than M.D.	1 (2.2%)	0
Never tried	1 (2.2%)	1 (16.7%)
Would call		
Wooton Clinic (FNS)	27 (60%)	1 (16.7%)
Other FNS	4 (8.9%)	3 (50%)
Cutshin Clinic	10 (22.2%)	0

* Percentages total more than 100 because some made multiple comments.

actually used or knew they could call upon if necessary as had designated particular physicians on the previous question. Of these, 60% (27) referred to FNS nurses at Wooton Clinic ("If it's late you call the nurses' house"), 8.9% (4) specified other FNS districts, and 22.2% (10) named to nurse at Cutshin Clinic who was an FNS graduate. The choices were not mutually exclusive, and some named two or three places (e.g., "I'd call Cutshin first, then Hyden or Wooton" or "I'd call Hyden and they would tell me who to call"). The fact that the recently established Wooton Clinic was the only place cited by 25 of the 27 who mentioned it is indicative of the vacuum it had begun to fill in a major and formerly decidedly underserved sector of the community.

The clinic (officially the MCHC Wooton Family Health Center) epitomizes the contrapuntal themes of isolation and integration, constancy and change that enliven the numerical and qualitative facts presented in this and later chapters. Without relinquishing their traditional base in family solidarity, the community's several neighborhoods have been drawn together toward mainstream activities and centralized services through improved roads, better means of transportation and communication, and a process of consolidation that has accelerated in recent years. Concurrently, outside styles and services have flowed into the neighborhoods with increasing persistence along with their supporting technologies and bureaucratic lines to public and private organizations from state and local to national levels. In this instance, it was representatives of the Frontier Nursing Service and the Mountain Comprehensive Health Corporation who met local citizens on the shared physical and partially shared social state of the Wooton area.

Chapter 1 has sketched the geographic setting and noted the circumscribed economy that has stranded up to two-thirds of the population below the poverty level. It has introduced the 14 full-time employees of the clinic and members of 51 local households and compared them demographically. Although the comparison revealed similarities of origin and family background, important differences put the residents at a greater disadvantage both in terms of individual risk and the ability to make the most effective use of modern medical care.

On one hand, the two groups belonged basically to a single system of branching, interlocking families and small rural settlements in a county with fewer than 12,000 inhabitants - a situation conducive to multiple social linkages and shared understandings about what life is like. On the other hand, the residents were in general less well equipped to command an equitable share in the tangible and intangible "goods" of contemporary American life. They were older, with more retired, disabled and widowed persons; they were less educated; and they had larger families - all factors contributing to reduced incomes and overtaxed resources. They were also more cut off from many services by road conditions and the relative lack of automobiles and telephones.

Residents nevertheless joined the staff in affirming that conditions have improved markedly in the past fifteen years, with respect to the quality and availability of health services if not always of health itself. Finally, the chapter began to examine expectations with regard to specific services, noting that while few really expected doctors to make house calls routinely any more, an over-whelming majority felt sure they could get a nurse. The analysis of such beliefs and experiential judgments becomes central in Chapter 2 which will consider doctors and nurses, hospitals, and problems of payment from the perspectives of Wooton residents and Wooton Clinic personnel.

TABLE 15. OPINIONS ABOUT DOCTORS AND NURSES ENDORSED BY THE WOOTON RESIDENTS (N=52)

	Doctors			Nurses		
Statement	True	False	DK	True	False	DK
A.	5(9.6%)	47(90.4%)	0	3(5.8%)	48(92.3%)	1(1.9%)
B.	9(17.3%)	43(82.7%)	0	4(7.7%)	47(90.4%)	1(1.9%)
C.	40(76.9%)	9(17.3%)	3(5.8%)	43(82.7%)	2(3.8%)	7(13.5%)
D.	6(11.5%)	44(84.6%)	2(3.8%)	1(1.9%)	48(92.3%)	3(5.8%)
E.	3(5.8%)	43(82.7%)	6(11.5%)	1(1.9%)	49(94.2%)	2(3.8%)
F.	15(28.8%)	35(67.3%)	2(3.8%)	2(3.8%)	49(94.2%)	1(1.9%)
G.	10(19.2%)	39(75%)	3(5.8%)	3(5.8%)	43(82.7%)	6(11.5%)
H.	43(82.7%)	9(17.3%)	0	26(50%)	25(48.1%)	1(1.9%)

*The statements were:

A. Doctors (Nurses) don't give you a chance to tell them exactly what is wrong.

B. They don't take enough personal interest in you.

C. They will tell you honestly when they don't know what is wrong with you.

D. They like to prescribe medicine even when you don't need it.

E. They don't like to get (another, a) doctor's opinion about a patient's trouble.

F. Doctors (Nurses) don't tell you enough; they don't explain things.

G. They tell you there's nothing much wrong when you know there is.

H. Doctors (Nurses) make you wait too long when you try to see them in their office or clinic.

TABLE 16. OPINIONS ABOUT DOCTORS AND NURSES ENDORSED BY THE CLINIC STAFF (N=14)

Statement*	Doctors			Nurses		
	True	False	DK	True	False	DK
A.	2(14.3%)	12(85.7%)	0	0	14(100%)	0
B.	6(42.9%)	8(57.1%)	0	0	14(100%)	0
C.	7(50%)	5(35.7%)	0	10(71.4%)	3(21.6%)	1(7.
D.	2(14.3%)	12(85.7%)	0	0	13(92.9%)	1(7.
E.	0	13(92.9%)	1(7.1%)	0	14(100%)	0
F.	5(35.7%)	6(42.9%)	2(14.3%)	0	14(100%)	0
G.	4(28.6%)	9(64.3%)	1(7.1%)	0	13(92.9%)	1(7.
H.	4(28.6%)	9(64.3%)	1(7.1%)	2(14.3%)	12(85.7%)	0

*The statements were:-

A. Doctors (Nurses) don't give you a chance to tell them exactly what is wrong.

B. They don't take enough personal interest in you.

C. They will tell you honestly when they don't know what is wrong with you.

D. They like to prescribe medicine even when you don't need it.

E. They don't like to get (another, a) doctor's opinion about a patient's trouble.

F. Doctors (Nurses) don't tell you enough; they don't explain things.

G. They tell you there's nothing much wrong when you know there is.

H. Doctors (Nurses) make you wait too long when you try to see them in their office or clinic.

TABLE 17. MODIFICATION OF TABLES 15 & 16 IN RELATION TO CONSISTENT AND INCONSISTENT EXAMPLES

	Wooton Residents		Clinic Staff	
Response/Example	M.D.	R.N.	M.D.	R.N.
A. Don't let you talk	11 (57.9%)	1 (6.7%)	1 (33.3%)	
+/consistent	3	1	0	
-/inconsistent	8	0	1	
Let you talk	8 (42.1%)	14 (93.3%)	2 (66.7%)	1
-/consistent	7	14	2	1
+/inconsistent	1	0	0	0
N =	19 (100%)	15 (100%)	3 (100%)	1
B. No personal interest	11 (52.3%)	4 (21%)	3 (75%)	
+/consistent	4	2	2	
-/inconsistent	7	2	1	
Personal interest	10 (47.6%)	15 (78.9%)	1 (25%)	3
-/consistent	10	15	0	3
+/inconsistent	0	0	1	0
N =	21 (99.9%)	19 (99.9%)	4 (100%)	3
C. Admit ignorance	11 (57.9%)	14 (87.5%)	2 (50%)	1
+/consistent	8	14	2	1
-/inconsistent	3	0	0	0
Don't admit ignorance	8 (42.1%)	2 (12.5%)	2 (50%)	
-/consistent	3	2	2	
+/inconsistent	5	0	0	
N =	19 (100%)	16	4 (100%)	1

able 17-Cont.

D. Unnecessary Rx	7 (43.8%)	1 (14.3%)	(No examples given)	
+/consistent	6	1		
-/inconsistent	1	0		
No unnecessary Rx	9 (56.2%)	6 (85.7%)		
-/consistent	9	6		
+/inconsistent	0	0		
N =	16 (100%)	7 (100%)		
E. Don't consult others	2 (10%)	1 (7.1%)	0	0
+/consistent	2	0		
-/inconsistent	0	1		
Consult others	18 (90%)	13 (92.9%)	2	1
-/consistent	18	13	2	1
+/inconsistent	0	0	0	0
N =	20 (100%)	14 (100%)	2	1
F. Don't explain	18 (75%)	5 (27.8%)	5 (83.3%)	(No exam
+/consistent	12	2	4	
-/inconsistent	6	3	1	
Do explain	6 (25%)	13 (72.2%)	1 (16.7%)	
-/consistent	6	13	1	
+/inconsistent	0	0	0	
N =	24 (100%)	18 (100%)	6 (100%)	

Table 17-Cont.

G. Dismiss complaint	8 (54.4%)	3 (30%)	0	0
+/consistent	7	3		
-/inconsistent	1	0		
Don't dismiss	7 (46.6%)	7 (70%)	1	1
-/consistent	7	7	1	1
+/inconsistent	0	0	0	0
N =	15 (100%)	10 (100%)	1	1
H. Wait too long	41 (95.3%)	25 (58.1%)	8 (88.9%)	5 (55.5%
+/consistent	36	21	3	2
-/inconsistent	5	4	5	3
Don't wait long	2 (4.6%)	18 (41.9%)	1 (11.1%)	4 (44.4%)
-/consistent	1	15	1	4
+/inconsistent	1	3	0	0
N =	43 (99.9%)	43 (100%)	9 (100%)	9 (99.9%

TABLE 44. THINGS WOOTON RESIDENTS AND CLINIC STAFF LIKE/DISLIKE ABOUT NURSES AT WOOTON CLINIC AND HYDEN HOSPITAL

	Wooton Residents		Clinic Staff	
	Wooton R.N's	Hyden R.N.'s	Wooton R.N.'s	Hyden R.N.'s
Like	(N=34)*	(N=46)*	(N=10)*	(N=10)*
Clinical competence	13(38.2%)	13(28.3%)	6(60%)	2(20%)
Other professional traits	15(44.1%)	15(32.6%)	3(30%)	1(10%)
Personal qualities	23(67.6%)	26(56.5%)	5(50%)	7(70%)
Call M.D. if needed	0	5(10.9%)	0	0
Honest with you	2(5.3%)	0	0	0
Don't keep you waiting	7(20.6%)	3(6.5%)	1(10%)	1(10%)
Arrivement location	1 (2.9%)	0	0	0
General approval	0	2(4.4%)	0	1(10%)
Dislike	(N=35)*	(N=47)*	(N=10)*	(N=11)*
Nothing disliked	26(74.3%)	28(59.6%)	9(90%)	6(54.5%)
Incompetent	2(5.7%)	9(19.1%)	0	1(9.1%)
Bad personal traits	0	12(25.5%)	0	3(27.3%)
Don't call M.D.	0	4(8.5%)	0	0
Advice given	2(5.7%)	2(4.3%)	1(10%)	1(9.1%)
Keep you waiting	3(8.6%)	8(17%)	0	1(9.1%)
Rush you through	0	1(2.1%)	0	1(9.1%)
Too much turnover	1(2.9%)	2(4.3%)	0	0
Hours incon.	1(2.9%)	0	0	0
Costs too much	1(2.9%)	0	0	0

*Percentages total more than 100 because some gave multiple reasons.

TABLE 45. THINGS WOOTON RESIDENTS AND CLINIC STAFF LIKE/DISLIKE ABOUT DOCTORS AT WOOTON CLINIC AND HYDEN HOSPITAL

	Wooton Residents		Clinic Staff	
	Wooton M.D.'s	Hyden M.D.'s	Wooton M.D.'s	Hyden M.D.'s
Like	(N=11)*	(N=44)*	(N=3)	(N=9)*
Clinical competence	5(44.5%)	17(38.6%)	2(66.7%)	3(33.3%)
Other professional traits	3(27.3%)	18(40.9%)	1(33.3%)	6(66.7%)
Personal qualities	3(27.3%)	25(56.8%)	0	3(33.3%)
O.K., nothing special	2(18.2%)	3(6.8%)	0	0
Don't have to wait	1(9.1%)	0	0	0
Dislike	(N=11)*	(N=46)*	(N=3)	(N=10)
Nothing disliked	8(72.7%)	37(80.4%)	2(66.7%)	6(60%)
Incompetent	2(18.2%)	3(6.5%)	0	0
Advice given	1(9.1%)	5(10.9%)	0	1(10%)
Keep you waiting	0	6(13%)	0	3(30%)
Rush you through	0	2(4.3%)	0	0
Embarrassed	1(9.1%)	0	1(33.3%)	0
Refused service	0	1(2.2%)	0	0
Too much turnover	0	1(2.2%)	0	0

*Percentages total more than 100 because some gave multiple reasons.

TABLE 46. THINGS WOOTON RESIDENTS AND CLINIC STAFF LIKE/DISLIKE ABOUT NON-PROFESSIONAL WORKERS AT WOOTON CLINIC AND HYDEN HOSPITAL

	Wooton Residents		Clinic Staff	
	Wooton Non-P	Hyden Non-P	Wooton Non-P	Hyden Non-P
Like	(N=32)*	(N=46)*	(N=9)*	(N=11)
Know their job	7(21.9%)	3(6.5%)	2(22.2%)	1(9.1%)
Helpful, concerned	4(12.5%)	0	1(11.1%)	0
Personal qualities	29(90.6%)	21(45.7%)	9(100%)	4(36.4%)
O.K., no problems	0	20(43.5%)	0	6(54.5%)
Provide transport	1(3.1%)	0	0	0
No contact	0	3(6.5%)	0	0
Dislike	(N=31)	(N=47)*	(N=9)	(N=11)*
Nothing disliked	29(93.5%)	21(44.7%)	9(100%)	6(50.9%)
Incompetent	0	10(21.3%)	0	3(27.3%)
Billing, records errors	0	16(34%)	0	0
Slow, keep you waiting	2(6.5%)	3(6.4%)	0	1(9.1%)
Rude, impersonal	0	6(12.8%)	0	1(9.1%)
Play favorites	0	2(4.3%)	0	2(18.2%)
May be dishonest	0	2(4.3%)	0	0

*Percentages total more than 100 because some gave multiple reasons.

A REVIEW OF THE PROBLEMS AND PROSPECTS OF THE PRIMEX ENCOUNTER FORM AS DEVELOPED AT THE FRONTIER NURSING SERVICE

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September, 1976
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Study and analysis of ambulatory care services is a relatively new interest among researchers, planners and providers in the health and medical field. Most attention has been focused on hospital-based services for which data gathering tools and instruments for measuring and evaluating effectiveness of services has been developed and refined. At the Frontier Nursing Service (FNS), located in southeastern Kentucky, efforts have been directed at studying, developing, and evaluating a variety of data gathering techniques that can address ambulatory as well as the institutional components. Services include the inpatient services at the Mary Breckinridge Hospital, the outpatient services or Primary Care Center, the six district clinics (or Primary Health Care Clinics), located throughout Leslie and Clay Counties, and the home health services now a part of a Home Health Agency.

The purpose of this paper is to briefly describe the design and use of the encounter form (E-Form) in the ambulatory care setting. The second section outlines some of the problems encountered with the E-Form and how the design of the most recent format has attempted to alleviate previous shortcomings. Final thoughts are directed to the importance of a good orientation program to ensure uniformity of data gathering and reliability of the data and information to be used by the various divisions within FNS.

An important factor in developing and using a method for analysis of primary care/ambulatory care treatment patterns is the type and quality of the data gathering tools. Over the past three years, the FNS has collected information on the outpatient visits of its patients through the use of an encounter form developed by staff at the FNS.

The development of an encounter form made it possible to gather data, process it through a computerized system (through the University of Kentucky computer facilities) and disseminate (in print-out form) information on every patient or procedure encounter within the FNS system. Since the implementation of the original form subsequent revisions have attempted to better adapt it to the present service system, current and anticipated research needs, and billing procedures.

Design of the Encounter Form

A one sheet encounter form was originally designed to gather information about each ambulatory care encounter. In its design, four areas needed to be considered:

1) Providers' use in hospital, district clinic and home settings;
2) Use by administrative personnel for purposes of billing and reimbursement of services;
3) Administrative and education staff use for purposes of service evaluation and planning; and
4) Research and analysis of service patterns.

Each category or subcategory was numbered for computerization purposes, with the exception of drugs prescribed or dispensed at the time of the encounter. Under this format drug information could only be obtained by consulting the medical record at the hospital or specific district clinic. Plans are being made for future computerization of medication data; drug codes have been developed. In terms of rapid data retrieval this old system proved to be time consuming and inadequate.

The 1974 and 1975 encounter forms contained the following categories: Status of visit, location of visit, patient registration, pay source, type of patient, primary or secondary visit, nurse clinic visit, reason for visit, tentative diagnosis (using ICDA codes), disposition, treatment and services, history, physical exam, general procedure, tests, drugs, immunizations and injections, lab/x-ray, drugs/supplies, provider time, provider skill code. The upper left corner of the form was for patient ID information, the upper right corner of the form was for billing information. (See attached forms)

Major changes in the 1975 encounter form focused on the section for drug information. Individual categories were reduced to three major groups; drug-refill, new drug, and drug administered. The second major change was "category of provider" in which the subcategory "provider time" was eliminated, since it proved cumbersome to determine exact times, or find the time to evaluate it and fill-in on the form.

The most marked changes occurred in the 1976 revision, which focused on data according to the problem-oriented approach used in the service setting (e.g. subjective/symptom, objective, assessment, plan). An additional reason was to obtain data that would yield information about 'reason for visit' and 'type of care' rendered with regard to curative and preventive services. This also included organizing the categories on the form in a more problem-oriented format. The sections: Assessment, Counseling and Instruction, constitute the most significant change. It was further divided (and coded) into preventive, maintenance, curative. (See attached form) Assessment categories were designed to gather information about exam procedures and health practices. Any assessment or counseling should pertain to problems stated under diagnosis and problems. The section Counseling and Instruction, was designed to record under what categories a provider did counseling or instruction as well as for what purpose (preventative, maintenance, curative).

The section previously categorized as treatment and services was revised to therapeutic procedures and care, thus separating those procedures related to curative purposes from those of preventive. Other changes included 1) the section under provider, (by changing the coding of which provider was directly involved in the assessment and treatment in an encounter); 2) marking which type of "consultant" or source of information, e.g. Medical Directives, the provider used.

Steps in Using the Encounter Form

An encounter can be identified as an outpatient clinic visit, a district clinic visit, a home visit, or a meeting with an FNS provider in another setting, e.g. on the side of the road. Wherever, an encounter form should be filled-out whether it is for a refill of medication or supplies or if a medical/health consultation has been undertaken.

After the provider has completed the form, it is sent to the FNS headquarters at the administrative offices in the old Hospital, where it is checked for completeness and key-punched for subsequent computerization at the University of Ketucky Center. Turn-around time from the point of filling-out the form to the processing and dissemination in print-out form, back at FNS, is approximately two months.

Analysis of Patterns of Care

In a recent study of FNS services, it was considered a valuable source of information, a well-designed encounter form is as valid as the medical record when analyzing resource use in a Primary Care environment.

In Figure I we can see where the encounter form fits into an analysis of patterns of care. Because data is computerized, it is possible to select diagnostic or disease specific case populations for analysis. At this point it is helpful to note the use of the tracer method (Kessner and Kalk) as an approach for analysis of patterns of care in all settings with the FNS system.

If, for example, we were interested in looking at possible variation in use of medication by different types of providers, or to what extent the type of provider affected the frequency and "quality" of a follow-up visit for a chronic diseased patient, a disease specific approach would allow for a more focused analysis. Using a tracer approach enables us to review resources (supplies, personnel) used, patterns of care, and costs to patient as well as to institution. The results obtained can be generalized in most instances to other disease/illness categories encountered in an ambulatory care setting. A distinction should be made, here, between the use of chronic disease tracers and acute illness tracers, each of which commands different patterns though in some settings mobilizing similar resources for care within the FNS system. The tracer approach is based on criteria, some of which need expansion on concept and category if applied to an ambulatory setting such as at the FNS. Briefly these original criteria are that:

1) A tracer should have a significant functional impact;
2) It should be relatively well defined and easy to diagnose in both field and practice setting;
3) Prevalence rates should be high enough to permit the collection of adequate data from a limited population sample;
4) The natural history of the condition should vary with utilization and effectiveness of medical care; and
5) Techniques of medical management should be well defined for at least one of the following processes: prevention, diagnosis, treatment, or rehabilitation.

In an ambulatory care setting, a problem lies in selecting a set or one tracer condition that is relevant for analyzing defined dependent variables and selecting disease/illness categories for which there is a sufficient data base, in which minimal variation exists in the data obtained.

Advantages and Disadvantages Related to the Encounter Form

The encounter form has been invaluable as a component to all aspects of service delivery and training in the family nurse practitioner and midwifery programs. Despite the numerous advantages, not least of which is the use of a single form for all providers and categories of ambulatory service and the computerized system, (in several areas) - thought needs to be given to additional revision and improvement. This concerns the design and implementation of the encounter form as well as orientation as to its use.

A general question is to what extent the encounter form (in its various designs) has helped generate a data base that is applicable to service, billing, and research. Can the form meet the data needs related to the objectives of each section? To ensure greatest possible reliability, it is essential that uniformity in filling-out the form be established. Related to this is the assurance of quality decision-making regarding the entry under each encounter category. With the revisions in encounter forms this has been an important concern.

Orientation of the various providers to the encounter form (in all its formats) has been a problem, given staff turn-over and the difficulty to ensure that each staff member, new and old, has received sufficient orientation regarding the mechanics of filling-out the form. After numerous meetings with different staff, a handbook useful to all parties was developed.

A second aspect is the level of understanding regarding the relationship between accuracy in recording data on an encounter form, to its subsequent use in a research or billing/reimbursement capacity. Reliability of data is imperative. In the area of research, for example, a major problem has been the layout and nomenclature in the earlier encounter forms, particularly as they related to diagnostic information. A limiting factor was the restriction in using the ICDA coding: 1) because of the number and types illnesses and disease categories; 2) because of the variation introduced in providers' evaluation of what code number to list for a particular condition.

Under the category of tentative diagnosis, research problems were compounded (e.g. when selecting out cases of a tracer such as otitis media or diabetes) because this section of the encounter form was being used as a "rule-out" section. This is often the practice as evidenced in the medical record, but inappropriate and impractical for the encounter form. Furthermore, with some patients, particularly those with a chronic disease or multiple problem mix, it was difficult to determine what was the primary problem for that encounter and how were the recorded treatments and procedures applied to all or one of the recorded diagnoses. In the new encounter form, the provider is forced to be more precise in thinking and recording the "why" and "what".

The revision in the encounter form was also designed to deal with earlier problems related to information about what drugs were prescribed for a particular condition. Computerization of drugs' name will clarify what was prescribed in the encounter as well as facilitate utilization review and service evaluation.

The time factor also became an important consideration. Time used in filling-out the form was a factor in potentially and actually creating variation in the data. In some instances a provider had become too systematic in the recording procedure, thus neglecting certain categories or marking the same sub-categories in each encounter form. Such practice had actually been minimal, however, changes must be made to ensure accuracy in this procedure. The new encounter form was partly designed with this latter problem in mind. Under the current form greater attention must be paid to data recorded under e.g. diagnosis/problem, assessment and therapeutic procedure. Related to accuracy of recording and the time factor is taking into account the practicalities of revising a form that will have to be filled-out under the pressures of clinic or a home visit. Each revision has tried to tailor the procedure to ensure a realistic time span in which the form can be completed.

Orientation to Use of the Encounter Form

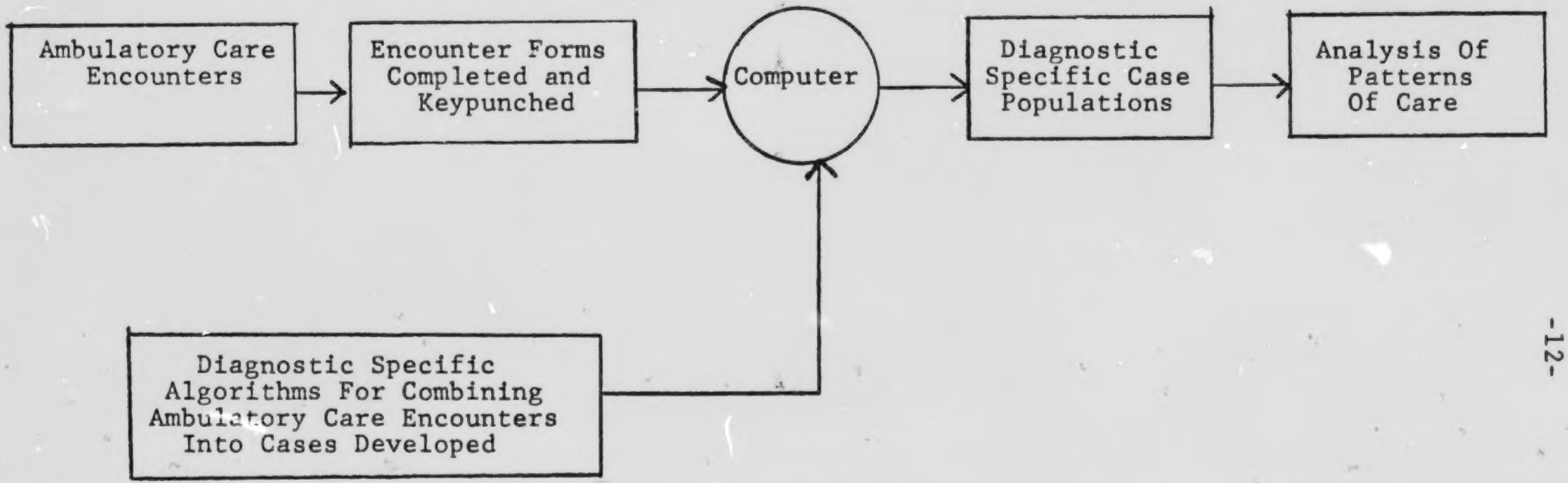
In order to deal effectively with some of the problems related to implementation of the encounter form, and to ensure minimization of procedural problems related to the new encounter form, more systematic efforts in orientation could be undertaken. The purpose would relate to service as well as the educational aspects of the FNS.

The "algorithmic" approach is a suggested approach for FNS, where there exists a variety of hospital and ambulatory services each using a variety of personnel (all of whom are at sometime responsible for using the encounter form). For all groups certain basic information is needed in the filling-out and processing procedures. This type of information would also include function of the form, or what clinic information should be included on the form (versus what is stated in patients' medical records). From this point specific information about the use and purpose of the form would be imparted to respective provider groups. This would include nurses, physicians, health aides (home and in-hospital), social workers, pharmacists, administrators, and researchers/planners. In an ambulatory care setting such as at the FNS, where one form is to be used by three major groups it is imperative that an orientation program address each of their information needs if most reliable data is to be obtained.

With each change in the E-Form and increasing experience in staff use, implementation procedures are being continually refined.

Figure 1

Model For Analysis of Patterns of Care


Ambulatory Care Encounters
Encounter Forms Completed and Keypunched
Computer
Diagnostic Specific Case Populations
Analysis Of Patterns Of Care
Diagnostic Specific Algorithms For Combining Ambulatory Care Encounters Into Cases Developed

SOURCE: Ira Moscovice, Development of a Method for the Analysis of the Utilization of Resources in an Ambulatory Care Setting, Yale University, 1976

SAMPLE ENCOUNTER FORMS **FRONTIER NURSING SERVICE ENCOUNTER FORM** 1974,1975,1976

SITE: ________________(District or Hospital Code)

DATE: ________________________________

STATUS OF VISIT ☐

1 - walk-in routine
2 - walk-in urgent
3 - appointment
4 - appointment urgent
5 - emergency
6 - telephone call (c. charting)
7 - broken appointment
8 - not at home (non-appt.)
9 - bill only/non-visit
0 - prescription only

PATIENT REGISTRATION ☐

1 - New to FNS 2 - Old
_____Registering for Midwifery
_____Other status change
_____Referred in from District

PAY SOURCES THIS VISIT ☐ ☐

1 - KMC
2 - Medicare Pt. A
3 - Medicare Pt. B
4 - MCHC
5 - BC/BS
6 - Other Ins./Workmen's Comp.
7 - Cash/Private Pay
8 - No Charge
9 - Prepayment
0 - Other

CHARGES

M.D. Visit [ ]	$.
Nurse Consult with M.D.	
Nurse Visit	.
Laboratory	.
X-Ray	.
EKG	.
Drugs and Solutions	.
Minor Surgery	.
Supplies, etc.	.
Inhalation Therapy	.
Physical Therapy	.
Family Plan. (Hosp. Only)	.
Emergency Room	.
Midwifery	.
Special Procedures	.
Other A– B– R– S– T– O	.
TOTAL CHARGES	.
Previous Balance	
+ Discount/Ins. Adj.	.
BALANCE DUE	.
AMOUNT PAID TODAY	.
Balance Left	.

LOCATION OF VISIT ☐☐

11 District Clinic
12 General Clinic - Hosp.
13 MTD Clinic
14 Peds (Hosp.) Clinic
15 Gyn (Hosp.) Clinic
16 Orthopedic (Hosp.) Clinic
17 Diagnostic Clinic
18 Other Hospital Clinic
20 Emergency Room
30 Hospital (Soc. Service)
40 Patient Home
80 Side of Road, Other

TYPE OF PATIENT ☐☐

01 Medical
02 Surgical/Orthopedic
03 Pediatric
04 Gyn
05 Prenatal
06 Postpartal
07 Neonatal
08 Family Planning
09 Other Midwifery
10 Other Specialty
11 Home Health

VISIT RELATED TO . . . prim ☐ sec ☐

1 Individual
2 Family
3 Animal

NURSE CLINIC VISIT ☐

1 Routine, initial
2 Routine follow-up
3 Extensive, initial
4 Extensive follow-up
5 Brief follow-up
6 No charge
9 Other, explain

SIGNATURE: ________________________________

RETURN ON: ________________TO SEE: ________________

COMMENTS/INSTRUCTIONS: ________________________

REASON FOR VISIT ☐☐ ☐☐

11 Acute Problem
12 Acute Follow-up
13 Chronic Problem, Routine
14 Chronic Problem, Flare-up
15 Check-up, Physical Assess.
16 Well Child/Baby Exam
17 Pre/post Partal Check
18 Family Planning
19 Post op/hosp. check
20 Minor Surgery
21 Treatment, Lab, Screen, Presc.
22 Health Promotion
91 Social Service
92 Other (trans., ref., etc.)
If transportation, mileage: ________________

TENTATIVE DIAGNOSIS
(See Reference Sheet for additional codes)

No abnormality 000.1
Pregnancy, normal 679.0
URI, acute 465.0
Otitis media 381.9 (externa 380.0)
Tonsillitis 463.0 (chronic 500.0)
Sinusitis 503.0 (acute 461.9)
Pharyngitis, unspec. 462.0 (strep 034.0)
Influenza 470.0
Bronchitis, acute 489.0 (chronic 491.0)
Respiratory allergy 507.9 (asthma 493.9)

COPD 492.0
Hypertension, essential (?) 401.0
ASHD 412.9
CHF 427.0
Diabetis Mellitus 250.0
Obesity 277.0
Ulcer, peptic 533.0 (stomach 531.0, duod. 532.0)
Osteoarthritis 713.0

Gastroenteritis, unspec. 009.2
Gastroenteritis, viral (flu) 008.9
Abdominal pain, ? etiol. 785.5
Intestinal parasites, unspec. 129.0
Urinary tract infection 599.9
Vaginitis 622.1 (monil. 112.2, trich 131.0)
Anemia, iron deficiency 280.9
Cellulitis 682.9
Rash, ? etiol. 788.2 (poison ivy 692.6)

Prim ☐☐☐☐ Other ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

DISPOSITION ☐☐ ☐☐

01 No follow-up planned
02 Phone follow-up planned
[illegible] Return PRN/SOS
[illegible]eturn at specific time
[illegible]efer/Return to District Clinic
06 Refer to Hyden Clinic (incl. M.D.)
07 Admit to Hyden Hospital
08 Refer to Social Service
09 Refer to Regional Hospital
10 Refer to U.K. Med. Center
11 Refer to other Hospital
12 Other referral (specify:________________).

TREATMENT AND SERVICES

HISTORY/PHYSICAL EXAM/COUNSELING

10 History only
11 History/physical, partial
12 History/physical, complete
13 Medical counseling
14 Psych., other counseling
15 Diet check, counseling
*16 Check medications
*17 Check body functions, skin condition
*18 Check edema, signs and symptoms
*19 Check vital signs
20 Teach self care (e.g. inj. tech.)

*These procedures should be checked ONLY when they are done alone, without a partial or complete history and physical.

GENERAL

21 No services required
22 Administrative procedure
23 Telephone consultation with M.D., Supervisor
24 Resource coordination
25 Other general procedure

PROCEDURES

26 Wound care/dressing
27 Suturing/suture removal
28 Sprain/dislocation treatment
29 Fracture/cast care
30 Minor surgery
31 Biopsy
32 IVP
33 Inhalation therapy
34 Diathermy
35 Exercises: walking, range of motion, etc.
36 Ear irrigation
37 Bath, other special assistance
38 Enema
39 Catheterization/Irrigation
40 IUD placement/removal
41 Other procedure: ________________

TESTS

45 EKG
46 X-Ray
47 Blood/urine test
48 Bacteriology
49 Parasitology
50 Pap Smear
51 PPD, Tine or Histo
52 Proctoscopy/Sigmoidoscopy
53 Pulmonary function test
54 Allergy skin test
55 Audiometry
56 Visual exam
57 Other test: ________________

DRUGS

60 Nutritional product
61 Blood modifiers
62 Hormone
63 Diuretic or Cardiovascular
64 Autonomic
65 Central nervous system drug
66 Gastrointestinal
67 Anti-infective
68 Biological
69 Other Drug: ________________

☐☐ ☐☐ ☐☐ ☐☐ ☐☐

IMMUNIZATIONS AND INJECTIONS

01– 1, 2, 3, 9	DPT 1, 2, 3, Booster
02– 1, 2, 9	D&T 1, 2, Booster
03– 1, 2, 9	Tet. Tox. 1, 2, Booster
04– 0	Tet. Antitoxin
05– 1, 2, 3, 9	Polio-Sabin (Oral) 1, 2, 3, Booster
06– 0	Measles
07– 1, 2, 3, 9	Flu Shot 1, 2, 3, Booster
20– 0	Allergy desensitization
21– 0	Merc. Injection
22– 0	Vitamin B-12
23– 0	Hormone shot
29– 0	Other injection specify below

☐☐☐ ☐☐☐ ☐☐☐

LABORATORY AND X-RAY (District Nurses Please Enter Codes)
See Reference Sheet for Codes

☐☐☐ ________ ☐☐☐ ________
☐☐☐ ________ ☐☐☐ ________
☐☐☐ ________ ☐☐☐ ________

DRUGS, SUPPLIES, SOLS., RENTALS, ETC.

ITEM	QUANTITY	CHARGES

PROVIDER TIME: PATIENT CONTACT

Provider No.	Skill Code	Duration (hr.)	Duration (min.)
☐☐☐	☐☐	☐	☐☐
☐☐☐	☐☐		☐☐
☐☐☐	☐☐		☐☐
☐☐☐	☐☐		☐☐

Other Providers Consulted ☐ ☐

1 MD by telephone
2 MD in person
3 Supervisor by phone
4 Supervisor in person
5 Other RN by phone
6 Other RN in person
9 Other: explain

SKILL CODES:

	FNP Grads:	FNP Trainees:	Other:
01 Physician			
03 RN	18 FN I	19 FN I	10 Pharmacist
04 LPN/LVN	28 FN I & II	29 FN I & II	90 Social Worker
05 Technician	38 FN I, II & III	39 FN I, II, & III	91 Med. Student
06 Recp/Sec	48 FN I, II & IV	49 FN I, II, & IV	
07 Nurse Aide	58 FN I, II, III, & IV	59 FN I, II, III & IV	98 Other
08 CRNA	68 Other FNP	69 Other Trainee	
	78 Midwife		

+Discount/Third Party codes for use at top:

D= routine discount, non-chargable items or hardship
M= midwifery charge prepaid
E= employee discount
C= courtesy discount
T= billable to Third Party

Rev. January 1974

Serial No.: C 000185

FRONTIER NURSING SERVICE ENCOUNTER FORM

ID CARD:

SITE: ____________________(District or Hospital Code)

DATE: ______________________________

STATUS OF VISIT ☐

1 - walk-in
2 - walk-in urgent
3 - appointment
4 - appointment urgent
5 - emergency
6 - telephone call (c. charting)
7 - broken appointment
8 - not at home (non-appt.)
9 - bill only/non-visit
O - prescription/supply only

NURSE VISIT ☐

1 Routine, initial
2 Routine follow-up
3 Extensive, initial
4 Extensive follow-up
5 Brief follow-up
6 Outside regular hours
7 Additional person/brief check
8 Health Promotion with NO Care
9 Health Promotion with Care

CHARGES

M.D. Visit ( ) $ ____
Nurse Visit ____
Laboratory ____
X-Ray ____
EKG ____
Drugs and Solutions ____
Operating Room Fee ____
Supplies, etc. ____
Inhalation Therapy ____
Physical Therapy ____
Family Plan. (Hosp. Only) ____
Emergency Room ____
Midwifery ____
Special Procedures ____
Other A– B– R– S– T– O ____
TOTAL CHARGES ____
Previous Balance ____
Ins. Coverage ____
BALANCE DUE ____
AMOUNT PAID TODAY ____
Balance Left ____

LOCATION OF VISIT ☐☐

11 District Clinic
12 General Clinic - Hosp.
13 MTD Clinic
14 Peds (Hosp.) Clinic
15 Gyn (Hosp.) Clinic
16 Orthopedic (Hosp.) Clinic
17 Diagnostic Clinic
18 Other Hospital Clinic
20 Emergency Room
30 Hospital (Soc. Service)
40 Patient Home
80 Side of Road, Other

TYPE OF PATIENT ☐☐

01 Medical
02 Surgical/Orthopedic
03 Pediatric
04 Gyn
05 Prenatal
06 Postpartal
07 Neonatal
08 Family Planning
09 Mental Health
10 Other Specialty
11 Home Health
12 Dental
13 Ophthalmology

VISIT RELATED TO . . . prim ☐ sec ☐

1 Individual
2 Family
3 Animal

PATIENT REGISTRATION ☐

1 - New to FNS 2 - Old
____Registering for Midwifery
____Other status change
____Referred in from District

PAY SOURCES THIS VISIT ☐ ☐

1 KMC
2 Medicare Pt. A
3 Medicare Pt. B
4 Workmen's Comp.
5 BC/BS
6 Other Ins.
7 Cash/Private Pay
8 S.L.U.
9 Employee
0 Other

SIGNATURE: ______________________________

RETURN ON: ______________ TO SEE: ______________

COMMENTS/INSTRUCTIONS: ______________________________

REASON FOR VISIT ☐☐ ☐☐

11 Acute Problem
12 Acute Follow-up
13 Chronic Problem, Routine
14 Chronic Problem, Flare-up
15 Check-up, Physical Assess.
16 Well Child/Baby Exam
17 Pre/post Partal Check
18 Family Planning
19 Post op/hosp. check
20 Minor Surgery
21 Treatment, Lab. Screen, Presc.
22 Health Promotion
91 Social Service
92 Other (trans., ref., etc.)

If transportation, mileage ______________

TENTATIVE DIAGNOSIS
(See Reference Sheet for additional codes)

No abnormality 000.1
Abdominal pain, ? etiol 780.0
Anemia, iron deficiency 280.9
Arthritis NOS 715.0 (Osteo 713.0, Rheu. 712.9)
ASHD 412.9
Bronchitis, acute 489.0 (chronic 491.0)
CHF 427.9
COPD 496.0
Dermatitis 692.9 (allergic, contact)
Diabetes mellitus 250.0
Diarrhea NOS 782.1
Gastroenteritis, unspec. 009.2 (viral, flu 008.9)
Headache 792.0 (tension 316.8)
Hypertension, essential (?) 401.0
Influenza 470.0
Intestinal parasites, unspec. 129.0
Obesity 277.0
Otitis media 381.9 (externa 380.0)
Pharyngitis, unspec. 462.0 (strep. 034.0, contact 906.2)
Poison ivy 692.6
Pregnancy, normal 679.0
Respiratory allergy 507.9 (asthma 493.9)
Sinusitis 503.0 (acute 461.9)
Tonsilitis 463.0 (chronic 500.0)
URI 465.0, Common cold 460.0
Urinary tract infection 599.9
Vaginitis 622.1 (monil. 112.2, trich. 131.0)
Vomiting, nausea 781.2

____

____

☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐
☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

DISPOSITION ☐☐ ☐☐

o follow-up planned
hone follow-up planned
03 Return PRN/SOS
04 Return at specific time
05 Refer/Return to District Clinic
06 Refer to M.B. Hosp. Clinic (incl. M.D.)
07 Admit to Mary Breckinridge Hospital
08 Refer to Social Service
09 Refer to Regional Hospital
10 Refer to U.K. Med. Center
11 Refer to other Hospital
12 Other referral (specify:______________).

TREATMENT AND SERVICES

HISTORY/PHYSICAL EXAM/COUNSELING

10 History only
11 History/physical, partial
12 History/physical, complete
13 Medical counseling
14 Psych., other counseling
15 Diet check, counseling
*16 Check medications
*17 Check body functions, skin condition
*18 Check edema, signs and symptoms
*19 Check vital signs
20 Teach self care (e.g. inj. tech.)

*These procedures should be checked ONLY when they are done alone, without a partial or complete history and physical.

GENERAL

21 Social/Health Promotion, No treatment rendered
22 Administrative procedure
23 Resource coordination
25 Other general procedures

PROCEDURES

26 Wound care/dressing
27 Suturing/suture removal
28 Sprain/dislocation treatment
29 Fracture/cast care
30 Minor surgery
31 Biopsy
32 IV Polygram
33 Inhalation therapy
34 Diathermy
35 Exercises: Physiotherapy
36 Ear irrigation
37 Bath, other special assistance
38 Enema
39 Catheterization/irrigation
40 IUD placement/removal
41 IV solutions, drugs or blood
42 Medical supplies
43 Dental services
44 Other procedures ______________

TESTS

45 EKG
46 X-Ray
47 Blood/urine test
48 Bacteriology
49 Parasitology
50 Pap Smear
51 PPD, Tine or Histo
52 Proctoscopy/Sigmoidoscopy
53 Pulmonary function test
54 Allergy skin test
55 Audiometry
56 Visual exam
57 Wet Smear
60 Other Test:

DRUGS

70 Drug/Prescription refill
71 New drug/Prescription given
72 Drug administered

☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐
☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐

IMMUNIZATIONS AND INJECTIONS

01-1,2,3,9	DPT 1, 2, 3, Booster
02-1,2,9	D & T 1, 2, Booster
03-1,2,9	Tet. Tox. 1, 2, Booster
04-0	Tet. Antitoxin
05-1,2,3,9	Polio-Sabin (Oral) 1, 2, 3, Booster
06-0	Measles
07-1,2,3,9	Flu Shot 1, 2, 3, Booster
081	Allergy desentitization
082	Merc. Injection
083	Vitamin B-12
084	Hormone shot
090	Other injection specify below

☐☐☐ ☐☐☐ ☐☐☐

Laboratory, X-ray and EKG *See manual for codes*

☐☐☐ ______ ☐☐☐ ______ ☐☐☐ ______
☐☐☐ ______ ☐☐☐ ______ ☐☐☐ ______
☐☐☐ ______ ☐☐☐ ______ ☐☐☐ ______

DRUGS, SUPPLIES, SOLS., RENTALS, ETC.

ITEM	QUANTITY	CHARGES

Provider No.	Skill Code		Other Providers Consulted
☐☐☐	☐☐	☐	1 MD by telephone 2 MD in person
☐☐☐	☐☐	☐	3 Supervisor by phone 4 Supervisor in person
☐☐☐	☐☐		5 Other RN by phone 6 Other RN in person
☐☐☐	☐☐		7 MD Supervision 8 Medical Directives
☐☐☐	☐☐		9 Other: Explain

SKILL CODES:

	FNP Grads:	FNP Trainees:	Other:
01 Physician	18 FN I	19 FN I	10 Pharmacist
03 RN	28 FN I & II	29 FN I & II	90 Social Worker
04 LPN/LVN	38 FN I, II & III	39 FN I, II, & III	91 Med. Student
05 Technician	48 FN I, II & IV	49 FN I, II, & IV	
06 Recp/Sec			
07 Nurse Aide	58 FN I, II, III, & IV	59 FN I, II, III & IV	98 Other
08 CRNA	68 Other FNP	69 Other Trainee	
	78 Midwife		

codes for use at top:

W= well-child allowance
M= midwifery allowance
E= employee discount
C= courtesy allowance
T= billable to Third Party

Rev. May 1975

400

SERIAL NO.

FRONTIER NURSING SERVICE ENCOUNTER FORM

12 - 080 - 98

ID CARD CODE SITE (CODE) DATE

NAME MED. RECORD NO.

RESPONSIBLE PARTY HOUSEHOLD NO.

[illegible] COUNTY

CITY STATE ZIP CODE

BIRTHDATE SEX RACE MAR STATUS LOC

[illegible]

OTHER INSURANCE NO. AND INFORMATION

DATES
CERT. ____
RECERT. ____
HOSP. ADM. ____
HOSP. DIS. ____

NURSE VISIT

- 1 ROUTINE INITIAL
- 2 ROUTINE FOLLOW UP
- 3 EXTENSIVE INITIAL
- 4 EXTENSIVE FOLLOW UP
- 5 BRIEF FOLLOW UP
- 6 OUTSIDE REGULAR HOURS
- 7 ADDITIONAL PERSON / BRIEF CHECK
- 8 HEALTH PROMOTION WITH NO CARE
- 9 HEALTH PROMOTION WITH CARE

PAY SOURCES THIS VISIT

- 1 KMC
- 2 MEDICARE PT. A
- 3 MEDICARE PT. B
- 4 WORKMEN'S COMP
- 5 BC / BS
- 6 OTHER INS.
- 7 CASH / PRIVATE PAY
- 8 S. L. U.
- 9 EMPLOYEE
- 0 OTHER

CHARGES

DESCRIPTION	AMOUNT	CODE
MD CLINIC VISIT ( )		
MD HOME VISIT ( )		
NURSE CLINIC VISIT		30
NURSE HOME VISIT		31
DRUGS & SOLUTIONS		250
E K G		200
EMERGENCY ROOM		500
INHALATION THERAPY		400
LABORATORY		40
OPERATING ROOM		300
PHYSICAL THERAPY		450
SPECIAL PROCEDURES		550
SUPPLIES, ETC.		350
X RAY		150
ANESTHESIA		600
RENTALS		650
SOCIAL SERVICE		700
TRANSPORTATION		750
TOTAL CHARGES →		
PAID TODAY		
ALLOWANCE ( )		
BALANCE LEFT		▨

BILLING CODE

COMMENTS / INSTRUCTIONS

SIGNATURE

LOCATION OF VISIT

DISTRICTS
- 10 PATIENT HOME
- 11 NURSE CLINIC
- 12 SPECIAL CLINIC ____ SPECIFY
- 19 SIDE OF ROAD, OTHER

MB HOSPITAL
- 20 GENERAL CLINIC
- 21 MTD CLINIC
- 22 PEDS CLINIC
- 23 GYN CLINIC
- 24 HEALTH ASSESSMENT CLINIC
- 25 ORTHOPEDIC CLINIC
- 26 NEUROLOGY CLINIC
- 27 OPHTHALMOLOGY CLINIC
- 28 OTHER SPECIAL CLINIC ____ SPECIFY
- 30 EMERGENCY ROOM

OTHER
- 40 SOCIAL SERVICE
- 41 TRANSPORTATION MILEAGE ____

TYPE OF PATIENT

- 1 WELL CHILD / ADULT
- 2 MEDICAL
- 3 SURGICAL / ORTHOPEDIC
- 4 GYN
- 5 PRENATAL
- 6 POSTPARTAL
- 7 NEONATAL
- 8 FAMILY PLANNING
- 9 PSYCHO / SOCIAL
- 0 OTHER SPECIALTY ____ SPECIFY

VISIT RELATED TO

- 1 INDIVIDUAL
- 2 FAMILY
- 3 ANIMAL

REGISTRATION

- 1 NEW
- 2 OLD
- 3 REG. FOR MIDWIFERY

HOME VISIT STATUS

- 1 CERTIFIED HOME HEALTH
- 2 PRIV. PAY HOME HEALTH
- 3 OTHER HOME VISIT

FINANCIAL CODES

W = WELL CHILD ALLOWANCE
M = MIDWIFERY
E = EMPLOYEE DISCOUNT
C = COURTESY ALLOWANCE
T = BILLABLE THIRD PARTY

DISPOSITION

RETURN ____ DATE
TO SEE ____
FOR ____
REFERRED TO ____

STATUS OF VISIT

- 1 WALK IN
- 2 APPOINTMENT
- 3 EMERGENCY
- 4 PRESCRIPTION, LAB OR X-RAY ONLY
- 5 RENTAL OR SUPPLY ONLY
- 6 NOT AT HOME
- 7 BROKEN APPT. / RE APPT. ONLY

SPECIAL PROGRAM STATUS

- 1 FAMILY PLANNING (KMC)
- 2 LOW / HIGH RISK MCH
- 3 EARLY & PERIODIC SCREENING (KMC)
- 4 FNS CHILD HEALTH
- 5 ANNUAL EMPL. PHYS.
- 9 OTHER ____ SPECIFY
- 0 NOT APPLICABLE

TYPE OF REFERRAL

- 1 NO REFERRAL
- 2 INSIDE FNS
- 3 COUNTY AGENCY / FACILITY
- 4 REGIONAL AGENCY / FACILITY
- 5 STATE AGENCY / FACILITY
- 6 OTHER ____ SPECIFY

REASON FOR VISIT

- 1 ACUTE PROBLEM / TRAUMA
- 2 ACUTE / TRAUMA FOLLOW UP
- 3 CHRONIC, ROUTINE
- 4 CHRONIC, FLARE UP
- 5 ASSESSMENT / PREVENTION

DIAGNOSIS / PROBLEM

TENTATIVE FINAL

DIRECT CARE PROVIDERS

SKILL CODE

SKILL CODE LIST

- 01 MD
- 02 PRIMARY CARE NURSE GRADUATE
- 03 PCN TRAINEE
- 04 RN
- 05 CRNA
- 06 LPN
- 07 AIDE / STUDENT NURSE
- 08 PHYSICAL THERAPIST
- 09 TECHNICIAN
- 10 PHARMACIST
- 11 SOCIAL WORKER
- 12 MEDICAL STUDENT
- 21 OTHER ____ SPECIFY

CONSULTANTS

SKILL CODE

- 18 MEDICAL DIRECTIVES
- 19 PLAN OF CARE
- 20 MISST LINE

ASSESSMENT COUNSELLING & INSTRUCTION

	PREVENTIVE	MAINTENANCE	CURATIVE
01 HISTORY	201	301	401
02 HX & PHYSICAL, COMPLETE	202	302	402
03 VITAL SIGNS	203	303	403
04 REVIEW & EXAM OF SYSTEMS, CONDITIONS (SEE CODES ON BACK)	204	304	404
05 DEVELOPMENTAL / CHILD CARE	205	305	405
06 PSYCHO / SOCIAL	206	306	406
07 PRE OP / PRE HOSPITAL CARE	207	307	407
08 POST OP / POST HOSPITAL CHECK	208	308	408
09 USE OF MEDICATIONS	209	309	409
HEALTH PRACTICES			
11 NUTRITION	211	311	411
12 ELIMINATION	212	312	412
13 SLEEP	213	313	413
14 PHYSICAL ACTIVITY	214	314	414
15 PERSONAL HYGIENE & GROOMING	215	315	415
16 FAMILY PLANNING	216	316	416
17 ENVIRONMENT	217	317	417
18 DRUG / ALCOHOL / TOBACCO USE	218	318	418
19 IMMUNIZATION	219	319	419
20 STRESS / GRIEF MANAGEMENT	220	320	420
21 INTER PERSONAL RELATIONS	221	321	421

THERAPEUTIC PROCEDURES & THERAPEUTIC CARE

- 01 SUTURE
- 02 SUTURE REMOVAL
- 03 WOUND CARE / DRESSING
- 04 FRACTURE / CAST CARE
  - A. CAST APPLIED
  - B. RECAST
  - C. CAST REMOVED
  - D. OTHER FRACTURE / CAST CARE
- 05 SPRAIN / DISLOCATION TREATMENT
- 06 MINOR SURGERY
- 07 ANESTHESIA, GENERAL
- 08 IVP DYE INJECTION
- 09 PROCTOSCOPY / SIGMOIDOSCOPY
- 10 EAR IRRIGATION
- 11 IUD INSERTION
- 12 IUD REMOVAL
- 13 ONCOLOGY THERAPY
- 14 OTHER SPECIAL PROCEDURES CPR, TRANSFUSION, OTHER SPECIFY ____
- 20 RESPIRATORY THERAPY
  - A. POSTURAL DRAINAGE
  - B. BREATHING EXERCISES
  - C. I P P B
  - D. OXYGEN THERAPY
- 21 PHYSICAL THERAPY
  - A. P & A EXERCISE / R O M
  - B. ULTRASOUND
  - C. WHIRLPOOL
  - D. DIATHERMY
- 22 PERSONAL CARE
  - A. BATH / BEDSIDE CARE
  - B. GROOMING / NAIL CARE
  - C. OTHER, SPECIFY ____
- 23 SKIN CARE
  - A. THERAPEUTIC
  - B. PREVENTIVE
  - C. DECUBITI
  - D. OTHER ULCERATIVE
- 24 ELIMINATION
  - A. CATHETER / IRRIGATION
  - B. ENEMA
  - C. IMPACTION REMOVAL
- 25 NG TUBE
- 26 OTHER CARE, SPECIFY ____

OTHER SERVICES
- 30 DELIVERY OF MED. SUPPLIES, MEDS
- 31 RESOURCE COORD. / ADMIN. PROC.
- 32 LONG DISTANCE TELEPHONE CALL FOR REFERRAL ____ LIST COST OF CALL

MEDICATIONS
- 40 NEW MEDICATION, PREPACK
- 41 MEDS REFILLED
- 42 NEW MEDS (RX) PRESCRIBED
- 43 PRESC (RX) RENEWED
- 44 MEDS ADM (INJ., TOPICAL, ORAL, IV)
- 45 CONTINUE PRESENT MEDS
- 46 ASPIRIN, OVER THE COUNTER DRUGS RECOMMENDED ____ SPECIFY

SPECIAL TESTS, LAB, EKG, X-RAY

IMMUNIZATIONS

- 01 - 1, 2, 3, 9 DPT 1, 2, 3, BOOSTER
- 02 - 1, 2, 9 D & T 1, 2, BOOSTER
- 03 - 1, 2, 9 TET. TOX 1, 2, BOOSTER
- 04 - 0 TET. ANTITOXIN
- 05 - 1, 2, 3, 9 POLIO - SABIN 1, 2, 3, BOOSTER
- 06 - 0 RUBELLA / RUBEOLA
- 07 - 1, 2, 9 FLU SHOT 1, 2, BOOSTER
- 08 - 0 OTHER IMMUNIZATIONS

MEDICATIONS, SUPPLIES, SOLD, RENTALS ETC.

ITEM	QUANTITY	CHARGES	MED CODE	PAY SOURCE
401				

ADDITIONAL SHOULD BE LISTED ON BACK OF PAGE

IAGNOSIS / PROBLEM - SHORT REFERENCE LIST

0 ABNORMALITY 000.1
BDOMINAL PAIN,? ETIOL 780.0
NEMIA, IRON DEFICIENCY 280.9
RTH[illegible]S NOS 715.0 (OSTEO 713.0, RHEU 712.9)
SHD[illegible].9
RONCHITIS ACUTE 489.0 (CHRONIC 491.0)
HF 427.9
OPD 496.0
ERMATITIS 692.9 (ALLERGIC, CONTACT)
IABETES MELLITUS 250.0
IARRHEA NOS 782.1
RACTURE 829.0
ASTROENTERITIS, UNSPEC. 009.2 (VIRAL, FLU 008.9)
EADACHE 792.0 (TENSION 316.8)
YPERTENSION, ESSENTIAL (?) 401.0
IFLUENZA 470.0
NTESTINAL PARASITES, UNSPEC. 129.0
BESITY 277.0
TITIS MEDIA 381.9 (EXTERNA 380.0)
HARYNGITIS, UNSPEC. 462.0 (STREP 034.0, CONTACT 906.2)
OISON IVY 692.6
REGNANCY, NORMAL 679.0
ESPIRATORY ALLERGY 507.9 (ASTHMA 493.9)
INUSITIS 503.0 (ACUTE 461.9)
ONSILITIS 463.0 (CHRONIC 500.0)
RI 465.0, COMMON COLD 460.0
RINARY TRACT INFECTION 599.9
AGINITIS 622.1 (MONIL. 112.2, TRICH. 131.0)
OMITING, NAUSEA, 781.2

ITEM	QUANTITY	CHARGES	MED CODE	PAY SOURCE

EXAM OF SYSTEMS:

50 SKIN
51 HEAD
52 EYES
53 ENT
54 NECK
55 NODES
56 BREASTS
57 RESPIRATORY
58 CARDIOVASCULAR
59 GI
60 GU
61 GYN
62 MUSCULOSKELETAL
63 NEUROLOGICAL

ROUTINE EXAM:

64 PRENATAL - INITIAL
65 PRENATAL - ROUTINE
66 POST PARTAL - ROUTINE
67 POST PARTAL 6 WEEK CHECK
68 FAMILY PLANNING
69 NEONATAL
70 WELL-CHILD

April, 1976

THE ENCOUNTER FORM HANDBOOK

Contents:

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The Encounter Form and the FNS System 2-08

II. The Encounter Form: 9-32
Section by Section

III. Appendices:

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    Samples for filling out the form, 33-41
2) Definition of Terms Used in the Encounter Form 42-44

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December 1976
The Frontier Nursing Service, Hyden, Kentucky

ENCOUNTER FORM

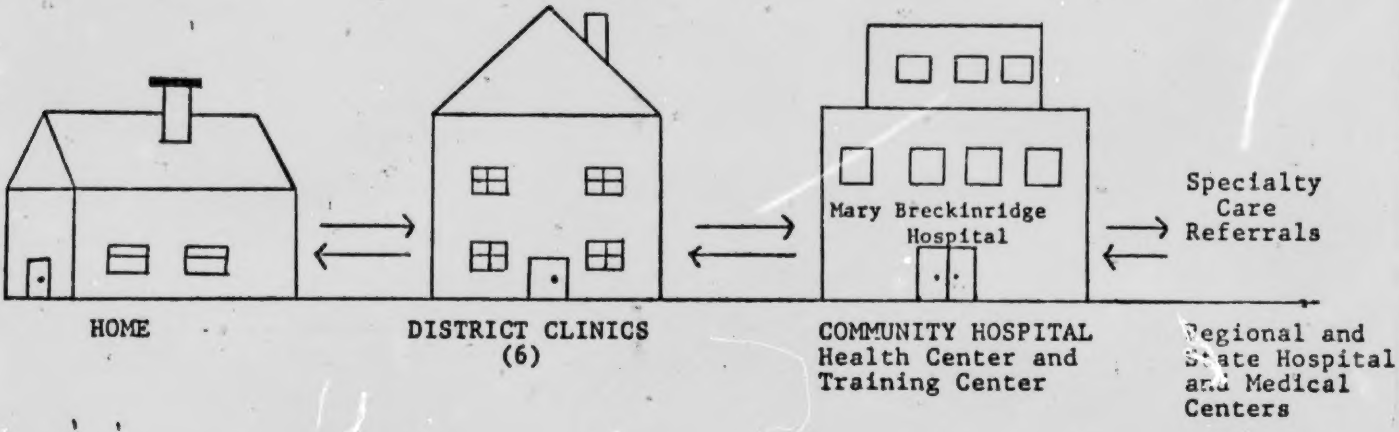
Introduction:

Purpose: The purpose of this handbook is to explain the mechanics of filling out the Encounter Form to insure uniformity and completeness of data, and why and where the Encounter Form fits into the FNS system. The Encounter Form is like a set of rules which guides the system of services. It is a tool which makes it easier to accomplish the objectives and goals of the FNS system of health care management.

A System of Services:

A system is made up of different components. Each component plays a vital role in the operation of a system. The system of services offered at the Frontier Nursing Service is made up of many different sections or service areas. What you do in one service area affects what happens in another.

Primary care services provided by the Frontier Nursing Service include the following:

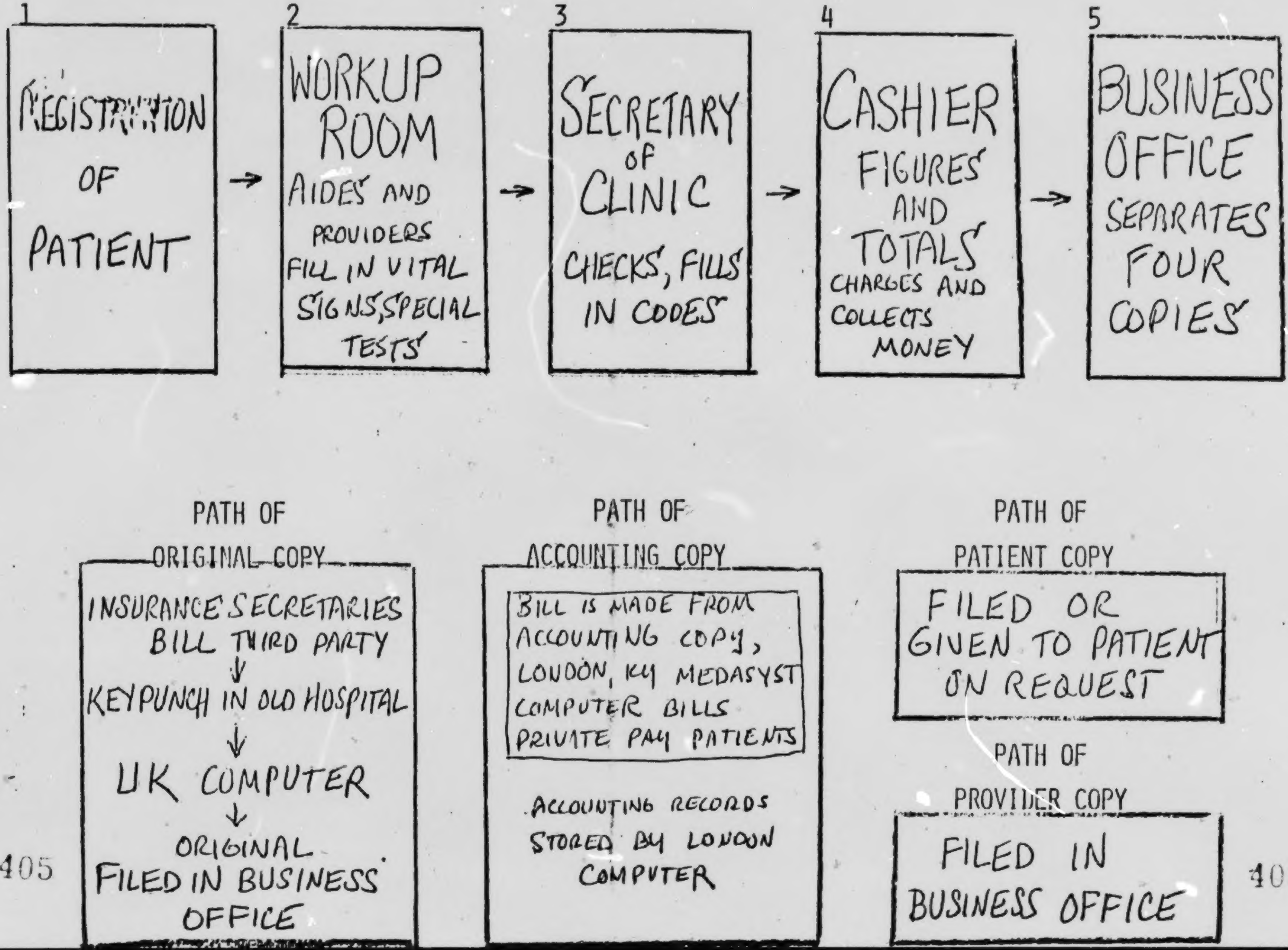

Mary Breckinridge Hospital
Specialty Care Referrals
HOME
DISTRICT CLINICS (6)
COMMUNITY HOSPITAL Health Center and Training Center
Regional and State Hospital and Medical Centers

The Encounter Form is one component that has a function in almost all service areas of the FNS system. As a single document, it reduces the number of forms to fill out, the duplication of data, and it helps streamline the functioning of the system.

Each of us who works with the Encounter Form has a specific job. Therefore, accuracy is important since other people within the system depend upon what we do.

The following diagrams illustrate the flow of the Encounter Form through the FNS system. There are three sections, each showing where the Encounter Form goes, in the Mary Breckinridge Hospital, the District Clinics, and the Home Health Agency.

PATH OF THE ENCOUNTER FORM AT THE MARY BRECKINRIDGE HOSPITAL



1 REGISTRATION OF PATIENT →

2 WORKUP ROOM
AIDES AND PROVIDERS FILL IN VITAL SIGNS, SPECIAL TESTS →

3 SECRETARY of CLINIC
CHECKS, FILLS IN CODES →

4 CASHIER
FIGURES AND TOTALS CHARGES AND COLLECTS MONEY →

5 BUSINESS OFFICE
SEPARATES FOUR COPIES

PATH OF ORIGINAL COPY

INSURANCE SECRETARIES BILL THIRD PARTY
↓
KEYPUNCH IN OLD HOSPITAL
↓
UK COMPUTER
↓
ORIGINAL FILED IN BUSINESS OFFICE

PATH OF ACCOUNTING COPY

BILL IS MADE FROM ACCOUNTING COPY, LONDON, KY MEDASYST COMPUTER BILLS PRIVATE PAY PATIENTS

ACCOUNTING RECORDS STORED BY LONDON COMPUTER

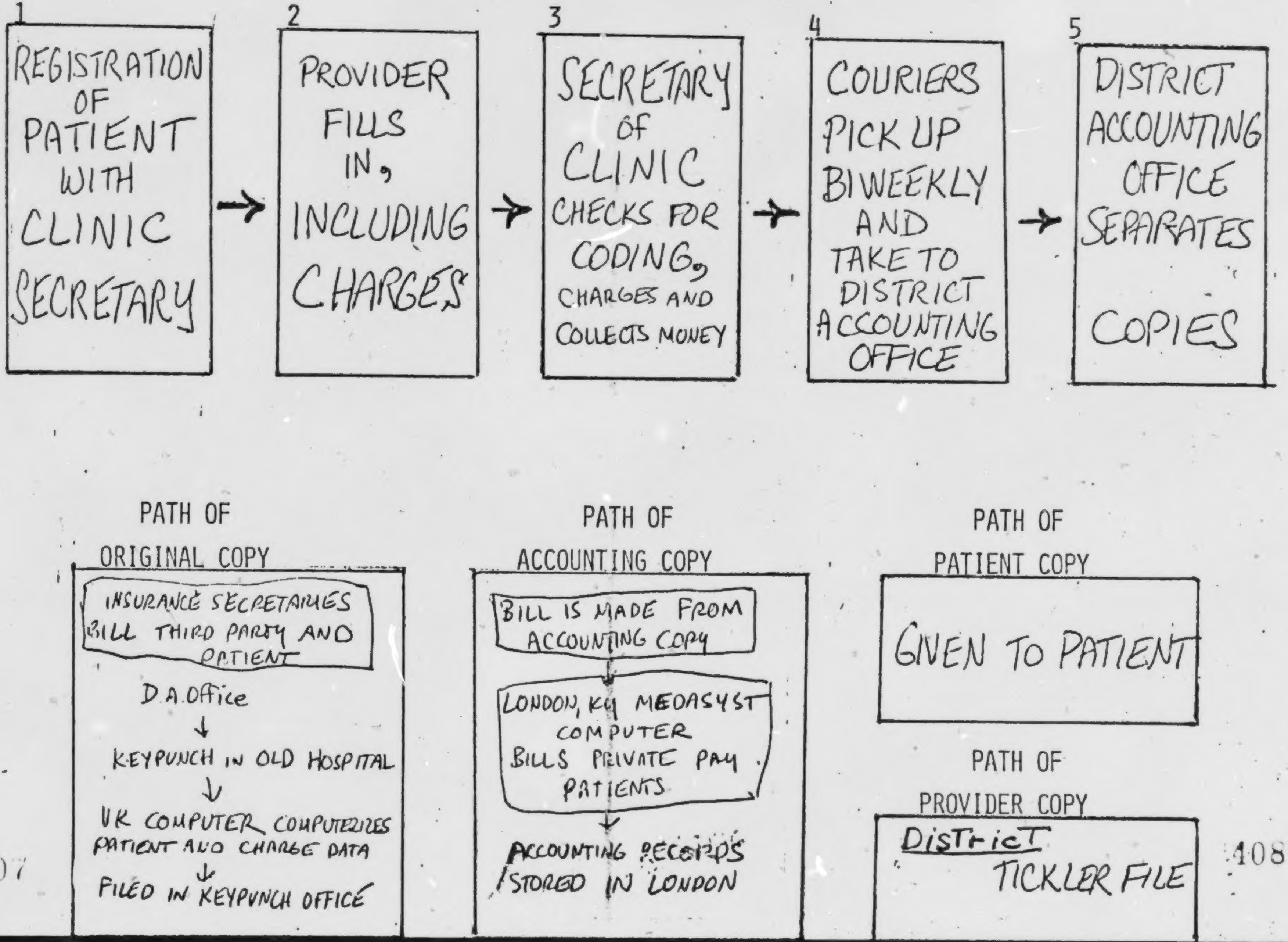
PATH OF PATIENT COPY

FILED OR GIVEN TO PATIENT ON REQUEST

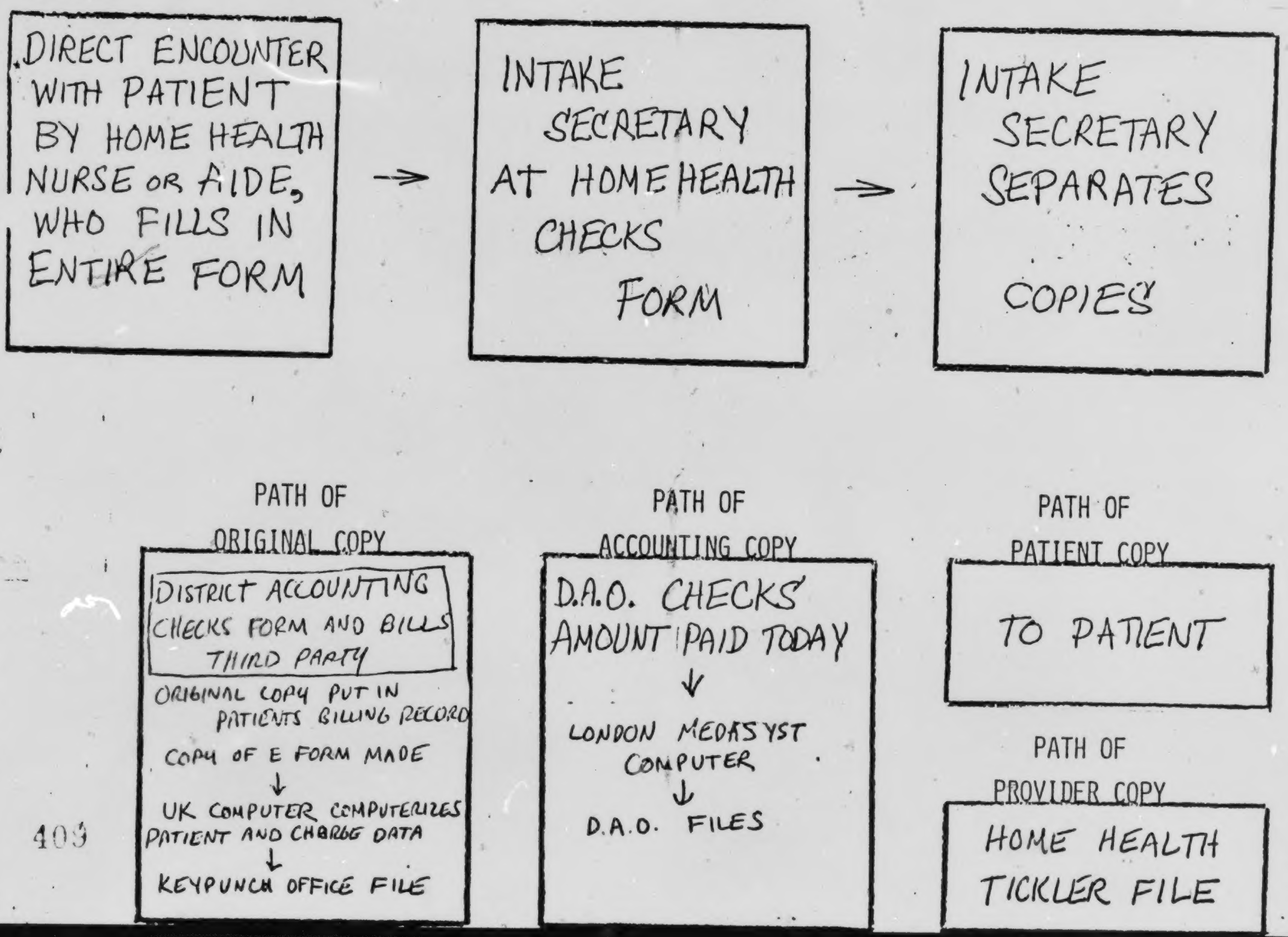
PATH OF PROVIDER COPY

FILED IN BUSINESS OFFICE

PATH OF ENCOUNTER FORM ON DISTRICT


1
REGISTRATION OF PATIENT WITH CLINIC SECRETARY
2
PROVIDER FILLS IN, INCLUDING CHARGES
3
SECRETARY OF CLINIC CHECKS FOR CODING, CHARGES AND COLLECTS MONEY
4
COURIERS PICK UP BIWEEKLY AND TAKE TO DISTRICT ACCOUNTING OFFICE
5
DISTRICT ACCOUNTING OFFICE SEPARATES COPIES
PATH OF ORIGINAL COPY
INSURANCE SECRETARIES BILL THIRD PARTY AND PATIENT
D.A. Office
KEYPUNCH IN OLD HOSPITAL
UK COMPUTER COMPUTERIZES PATIENT AND CHARGE DATA
FILED IN KEYPUNCH OFFICE
PATH OF ACCOUNTING COPY
BILL IS MADE FROM ACCOUNTING COPY
LONDON, KY MEDASYST COMPUTER BILLS PRIVATE PAY PATIENTS
ACCOUNTING RECORDS STORED IN LONDON
PATH OF PATIENT COPY
GIVEN TO PATIENT
PATH OF PROVIDER COPY
DISTRICT TICKLER FILE

PATH OF THE ENCOUNTER FORM AT HOME HEALTH AGENCY


DIRECT ENCOUNTER WITH PATIENT BY HOME HEALTH NURSE OR AIDE, WHO FILLS IN ENTIRE FORM
INTAKE SECRETARY AT HOME HEALTH CHECKS FORM
INTAKE SECRETARY SEPARATES COPIES
PATH OF ORIGINAL COPY
DISTRICT ACCOUNTING CHECKS FORM AND BILLS THIRD PARTY
ORIGINAL COPY PUT IN PATIENTS BILLING RECORD
COPY OF E FORM MADE
UK COMPUTER COMPUTERIZES PATIENT AND CHARGE DATA
KEYPUNCH OFFICE FILE
PATH OF ACCOUNTING COPY
D.A.O. CHECKS AMOUNT PAID TODAY
LONDON MEDASYST COMPUTER
D.A.O. FILES
PATH OF PATIENT COPY
TO PATIENT
PATH OF PROVIDER COPY
HOME HEALTH TICKLER FILE

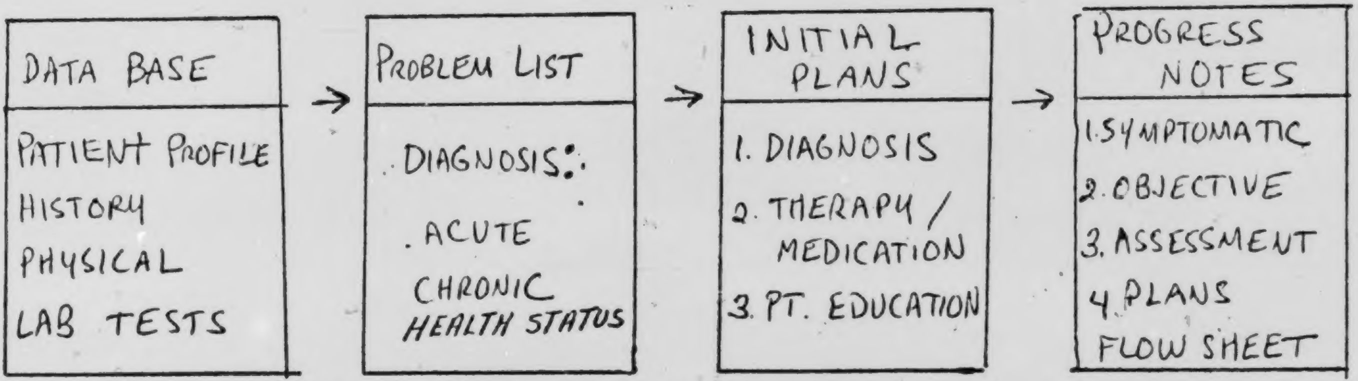
The Encounter Form and the Problem-Oriented Record System:

The FNS is in the process of adapting to the problem-oriented record. The Problem-Oriented Record System serves as an organizing principle. Let us review the basic components of a Problem-Oriented System. These are:

1) The Data Base
2) A Complete Problem List
3) Initial Plans
4) Progress Notes (SOAP)

Since this is problem-oriented, each component has an important function. The Encounter Form has been designed so that each section on the form relates to the other sections. As a single document the Encounter Form simplifies much of the clinical recording and provides a logicial set of procedures in a problem-oriented format. It reflects all that was done with the patient and it provides a check list to see if everything needed for the patient was covered.

The information on the E-Form must coincide with the information written in the record in a POR Form.


DATA BASE
PATIENT PROFILE
HISTORY
PHYSICAL
LAB TESTS
→
PROBLEM LIST
DIAGNOSIS:
. ACUTE
CHRONIC
HEALTH STATUS
→
INITIAL PLANS
1. DIAGNOSIS
2. THERAPY / MEDICATION
3. PT. EDUCATION
→
PROGRESS NOTES
1. SYMPTOMATIC
2. OBJECTIVE
3. ASSESSMENT
4. PLANS
FLOW SHEET

Importance of Data:

What is recorded on the Encounter Form makes up a data base essential for:

1) Billing:

FNS, like other medical organizations, must be reimbursed for the services it provides in order to pay for services provided. All persons receiving services must be charged for specific procedures and supplies obtained. Most charges vary with type of patient and type of encounter. The Total Charge is made on a per patient basis.

Some patients will pay at the time of a clinic visit or home visit; others will be covered by third party such as Blue Cross or KMC, or billed by mail.

The Encounter Form is a record of services rendered, charges, and amount paid. When you fill out the Encounter Form, you become part of the Billing Process.

2) Accountability and Audit:

The Encounter Form enables us to keep a record of what each practitioner does during an encounter. We must account for time, money, and resources used, just as a businessman keeps records of what happens in a business.

3) Research and Reporting:

In order to back up what we say about our system of services, we need evidence that accounts for what works or does not work. Statistics that are gathered from the data on the Encounter Form show what patterns emerge from the many daily activities.

Research helps sort out information of what happens on a daily, monthly, and yearly basis both within the FNS and among other medical institutions. If the Encounter Form is only partially filled out, certain sections are skipped, or charges listed inaccurately, the form becomes virtually useless. A reliable data base and statistics are important for good quality research.

Why research?--- The organization of services, the use of family nurses and midwives, and our location in a rural area, combine to form a unique experience.

On the basis of information obtained from the Encounter Form we try to answer questions that many other medical institutions and health service organizations are asking too. Our documented experience can serve as a model which is useful to similar organizations.

When you fill out the Encounter Form you become part of the research process.

4) Education:

The Encounter Form can be used as an educational tool. Periodic review of Encounter Forms provides feedback on clinical performance of family nurse and midwifery students.

5) Planning:

All systems are dynamic. Personnel in the organization change, needs for service change. In order to plan for future service resources, there must be a good base of information. The Encounter Form is one of the major sources of FNS service planning information.

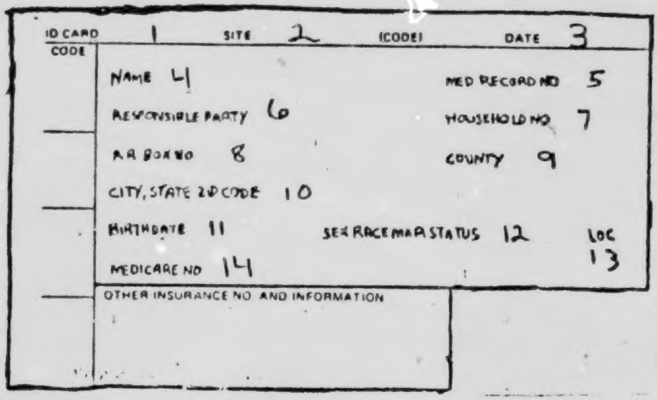
6) Patients:

The Encounter Form can display to a patient what procedures were covered during an encounter. It serves as a record that informs the patient what was done and how much procedures and supplies cost.

The Encounter Form (E-Form) Section by Section:

Note: You should have an E-Form next to you while reading this booklet.

The top half of the form contains information that helps describe the context in which a problem is treated. By "context" we mean the setting e.g. district, clinic or the Mary Breckinridge Hospital; the situation e.g. status of visit; and who was giving treatment or consultation. The bottom half of the form contains information as to why an encounter took place and what was done.



ID CARD CODE 1 SITE 2 (CODE) DATE 3

NAME 4 MED RECORD NO 5

RESPONSIBLE PARTY 6 HOUSEHOLD NO 7

R.R. BOX NO 8 COUNTY 9

CITY, STATE ZIP CODE 10

BIRTHDATE 11 SEX RACE MAR STATUS 12 LOC 13

MEDICARE NO 14

OTHER INSURANCE NO. AND INFORMATION

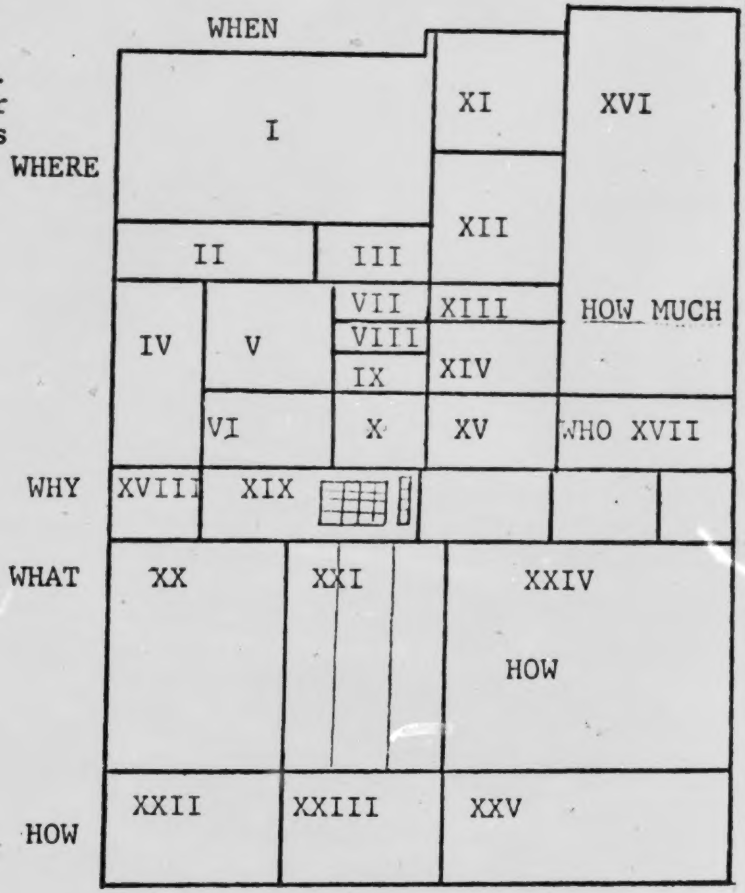
SECTION I: I.D. Information: This refers to entire I.D. Section.

1. MBH "ID Card Code" is to be filled in by the Cashier.

   District - Enter number 11 under "Code" for all patients new to the system, e.g. seen for the first time by any FNS staff.

   Home Health - (same as District)

   Please use ID cards. If no ID card is available, write in all ID information.


WHEN
I
XI
XVI
WHERE
XII
II
III
IV
V
VII
VIII
IX
XIII
XIV
HOW MUCH
VI
X
XV
WHO XVII
WHY
XVIII
XIX
WHAT
XX
XXI
XXIV
HOW
XXII
XXIII
XXV
HOW

All patients should have an ID Card to keep with the record. ID Cards are the same for the hospital and the district. New ID Cards are being issued:

a. To change household number to responsible party record number.

b. To provide new ID information.

c. To give regular medical record numbers to O.D. patients.

2. Site Code: Enter your site code (where encounter occurs).

Districts

01 - Brutus
02 - Red Bird
03 - Flat Creek
04 - Bob Fork
05 - Hyden
06 - Onieda
07 - Wendover
08 - Wolf Creek
09 - Beech Fork
10 - Clinic (all OPD-MBH Clinics)
11 - MTD - Home - Hospital

Others

22 - Social Service
23 - Transportation (non-visit)
24 - Rentals (non-visit)
25 - Home Health - HH must enter District Site number after code e.g. Site 25 (Code 01).

3. Date: Date of visit and date on chart must coincide with date on E-Form filled out. This is important for audit, billing, and research.

4. Name: Last name first, given name (please use proper name, do not use nicknames), middle initial or name.

5. Medical Record Number: To issue a new number a District must contact the hospital medical records to ascertain if the patient has a number. If the patient has a number, medical records will give this to the secretary. If there is no record, medical records will issue a number.

The medical record number is at present the patient's account number. It is important to enter the number as it appears on the ID Card. If transposed or entered incorrectly, the wrong person will receive a bill.

The District secretary then fills out form number 237B and sends it in to Medical Records, Mary Breckinridge Hospital. An ID Card will be issued.

6. Responsible Party: List full name of person responsible for payment of bill. Usually this is the head of the household. It may be self, husband, or father, wife, mother.

7. Household Number: The new household number is the medical record number of the person responsible for paying the bill. This is entered on all E-Forms and will serve as the account number for each family.

8. R.R. Number: If available, also include post office box number.

9. County: List county in which patient resides. Use list of county codes for Kentucky. (See reference list for others.)

Leslie	- 066	Breathitt	- 013
Clay	- 026	Harlan	- 048
Perry	- 097	Knox	- 061
Owsley	- 095	Bell	- 007

If out of State, use 999, for county code.

10. City, State and Zip Code: These must be accurate for billing purposes.

11. Birthdate: Write month, date and year (accuracy is important for identification).

12. Sex - Race - Marital Status:

Sex: 01 Male
02 Female

Race: (This includes ethnic groups)

1 - White
2 - Black
3 - Oriental
4 - Hispanic
5 - Other

Marital Status: 1 - Single
2 - Married
3 - Other (Divorced, Separated Widow/Widower)

13. Location:

1 - In District
2 - Out of District (O.D.)
3 - Out of State

14. Medicare Number: Ask patients for red, white, blue card.

Note: Animal Care

ID:
Name:
Sex:
Race:
Marital Status:
Responsible Party:
Medical Record No:
Birthdate:

99-9999
Type of animal, plus last name of owner
M or F
8 – Race
3 – marital Status
Owner's name
Owner's number (for accounting copy)
99-99-99- Date of Birth

SECTION II: Other Insurance Number and Information:

Please list name and number as recorded on the card (patient's insurance card which includes Medicaid, Blue Cross/Blue Shield, etc.). List address of company.

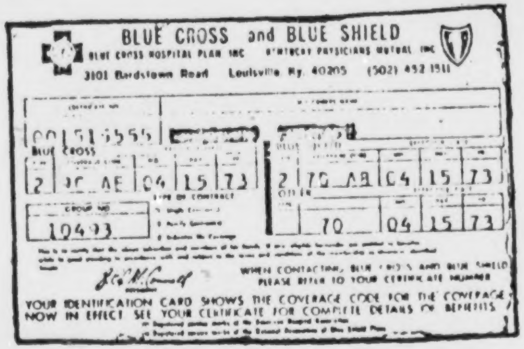
Include any mistakes in the spelling of the patient's name. This is important as it will reduce rejections of insurance billing. Be sure the card is current. The expiration date must be checked on the card since KMC, for example, expires each month.

The following is an example:

For Blue Cross/Blue Shield information must include:

Certificate
Group Number
Coverage Codes
Effective Dates

OTHER INSURANCE NO. AND INFORMATION
Cert #- 00151555 BC/BS
Gp. # - 10493
Cov. Code - 70 AB
Effective Date - 4-15-73



BLUE CROSS and BLUE SHIELD
BLUE CROSS HOSPITAL PLAN INC KENTUCKY PHYSICIANS MUTUAL INC
3101 Bardstown Road Louisville, Ky. 40205 (502) 452 1511

00151555 [redacted] [redacted]

BLUE CROSS 2 70 AB 04 15 73
BLUE SHIELD 2 70 AB 04 15 73
OTHER 70 04 15 73

GROUP NO 10493

TYPE OF CONTRACT

WHEN CONTACTING BLUE CROSS AND BLUE SHIELD PLEASE REFER TO YOUR CERTIFICATE NUMBER

YOUR IDENTIFICATION CARD SHOWS THE COVERAGE CODE FOR THE COVERAGE NOW IN EFFECT. SEE YOUR CERTIFICATE FOR COMPLETE DETAILS OF BENEFITS.

Patients must be charged for the visit even if they do not have their insurance card with them.

SECTION III: For Home Health Agency. Cert., Recert., Hosp. Adm., and Hosp. Dis. Dates:

Cert. and Recert. dates must be listed on Home Health patients only. Hosp. Adm. and Hosp. Dis. dates must be listed on all patients. Cert. refers to original plan of treatment date. Recert. refers to subsequent certification of plan.

DATES
CERT. ____________
RECERT. ____________
HOSP. ADM. ____________
HOSP. DIS. ____________

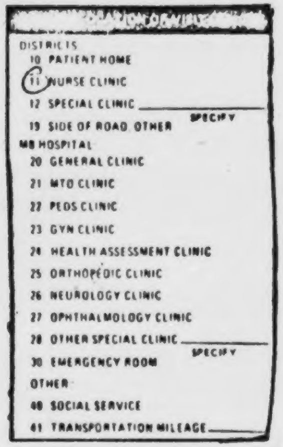
All patients on Home Health plan must be recertified every 60 days by a physician. The most recent date must be filled in.

SECTION IV: Location of Visit:

Circle one code only. This must be filled in on all Encounter Forms.

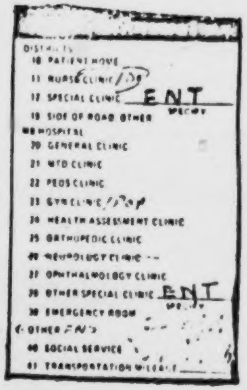
District:

10 - Patient's Home
11 - Clinic Visit - All visits in clinic setting whether medical or nursing clinic.
12 - Special Clinic - Any clinic conducted by non-FNS staff, e.g. ENT
19 - Side of Road or Other - This includes telephone calls or any other encounter. Notation on chart is required.


LOCATION OF VISIT
DISTRICTS
10 PATIENT HOME
[✓ 11] NURSE CLINIC
12 SPECIAL CLINIC ______ SPECIFY
19 SIDE OF ROAD OTHER
MB HOSPITAL
20 GENERAL CLINIC
21 MTD CLINIC
22 PEDS CLINIC
23 GYN CLINIC
24 HEALTH ASSESSMENT CLINIC
25 ORTHOPEDIC CLINIC
26 NEUROLOGY CLINIC
27 OPHTHALMOLOGY CLINIC
28 OTHER SPECIAL CLINIC ______ SPECIFY
30 EMERGENCY ROOM
OTHER
40 SOCIAL SERVICE
41 TRANSPORTATION MILEAGE ______

Mary Breckinridge Hospital:

20-24 - Regular Hospital Clinic Service
25-28 - Clinics conducted by non-FNS staff
30 - Emergency Room: To be used if Emergency Form is filled out. (Note: The pink copy of ER sheet must be attached to the E-Form as it is handed to cashier. The pink copy is used in billing.)


DISTRICTS
10 PATIENT HOME
11 NURSE CLINIC
12 SPECIAL CLINIC ENT SPECIFY
19 SIDE OF ROAD OTHER
MB HOSPITAL
20 GENERAL CLINIC
21 MTD CLINIC
22 PEDS CLINIC
23 GYN CLINIC
24 HEALTH ASSESSMENT CLINIC
25 ORTHOPEDIC CLINIC
26 NEUROLOGY CLINIC
27 OPHTHALMOLOGY CLINIC
28 OTHER SPECIAL CLINIC ENT SPECIFY
30 EMERGENCY ROOM
OTHER
40 SOCIAL SERVICE
41 TRANSPORTATION MILEAGE ______

Other:

29 - Dental

40 - Social Service will use this number if they see a patient on the ward or in their office. Otherwise they will use the location number in which the patient was seen. They have their own site number to identify patients seen by them.

41 - Transportation/Mileage. List mileage, if you transport a patient you must list the mileage e.g. 60 miles. Total charge is to be entered under transportation in Charge Section, e.g. 15¢ per mile.

SECTION V: Type of Patient:

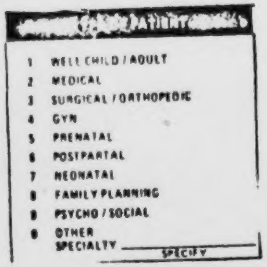
Circle one code only. This must be filled in on all Encounter Forms.

Type of patient must be coded as follows:

1 - Use Well Child/Adult if individual comes for well child or rountine check. Please Note: Date of birth will indicate whether an individual seen is a pediatric patient.

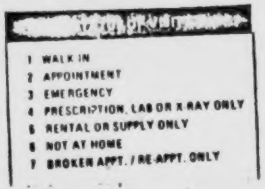
2-9 - is self-explanatory and refers to patients that come in for specific clinics under these categories.

0 - Other Specialty - Please specify e.g. ENT, Opthalmology, Dental.



[illegible] PATIENT [illegible]

1 WELL CHILD / ADULT
2 MEDICAL
3 SURGICAL / ORTHOPEDIC
4 GYN
5 PRENATAL
6 POSTPARTAL
7 NEONATAL
8 FAMILY PLANNING
9 PSYCHO / SOCIAL
0 OTHER SPECIALTY ______
SPECIFY



[illegible] OF VISIT [illegible]

1 WALK IN
2 APPOINTMENT
3 EMERGENCY
4 PRESCRIPTION, LAB OR X-RAY ONLY
5 RENTAL OR SUPPLY ONLY
6 NOT AT HOME
7 BROKEN APPT. / RE-APPT. ONLY

SECTION VI: Status of Visit:

Circle one code only. This must be filled in on all Encounter Forms.

1-4 - These are counted as actual visits for professional services.

5-7 - These are non-visits e.g. not requiring professional services.

Note number 5, Rental of Equipment: District rental is the responsibility of the Home Health Agency. MBH and clinic rentals are the responsibility of the Business Office.

1. Walk-in - any person who comes into the clinic without an appointment.
2. Appointment - persons who come to clinic with an appointment.
3. Emergency - persons who come in without an appointment and do not constitute walk-in patients.
4. Prescription, Lab, or X-ray only - persons who have come to clinic or receive a home visit in order to fulfill a prescription, lab, or x-ray. Note: One of these must be underlined. For refill of prescription, underline prescription.
5. Rental or Supply only - for supplies dispensed or delivered.
6. Not at Home - visit was scheduled, patient not at home.
7. Broken Appt./Re-Appt. only - no services rendered. Signature and code number of provider and skill code are noted. If reappointment is made, list date and time of next visit. This would come under disposition.

SECTION VII: Visit Related To:

Circle one code only.

1. If services are related to patient only.
2. If services include family members, (e.g. counseling or assessment).
3. For animals. If an animal is seen, use #99-999 for medical record and #99-99-99 for birthdate. Be sure to fill out responsible party, household number and all other information. This is essential for billing and statistics.

SECTION VIII: Registration:

You may circle two codes, new or old, and registration for MTD.

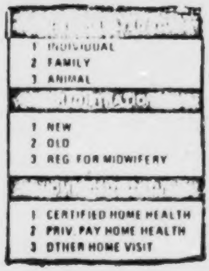
1. Any person new to FNS services. Make sure to get accurate ID information. The new medical record number should be provided.
2. All patients who have previously received FNS service.
3. Any prenatal patients coming in for the first visit. Be sure to fill out appropriate forms.

SECTION IX: Home Visit Status:

Circle one code only. Fill out only if home visit is made.

1. For patients with plan of treatment under third party payors. These must be recertified every 60 days for Home Health Agency only.
2. Private pay patient with plan of treatment for home visit.

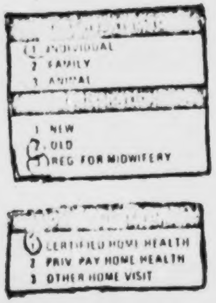
   Private pay patient with plan of treatment for home visit. Recertification is required every 60 days, and at the time a physician asks the home health nurse for a progress report on the patient.
3. All other home visits made by home health, District, MTD, or MBH personnel for home health or home assessment, acute sick call, or health promotion.



1 INDIVIDUAL
2 FAMILY
3 ANIMAL

1 NEW
2 OLD
3 REG FOR MIDWIFERY

1 CERTIFIED HOME HEALTH
2 PRIV. PAY HOME HEALTH
3 OTHER HOME VISIT



[✓ 1] INDIVIDUAL
2 FAMILY
3 ANIMAL

1 NEW
[✓ 2] OLD
[✓ 3] REG FOR MIDWIFERY

[✓ 1] CERTIFIED HOME HEALTH
2 PRIV. PAY HOME HEALTH
3 OTHER HOME VISIT

SECTION X: Special Program Status:

Circle one code only. This must be coded for all patients.

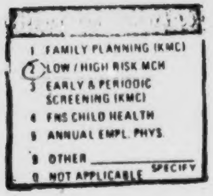
1. Any patient that comes in for Family Planning with KMC Card.

2. Any patient without KMC receiving midwifery services in Leslie County or that reside in KRAD. This includes the counties: Leslie, Perry, Owsley, Breathitt, Knott, Letcher, Lee, and Wolf. Any family nurse or midwife can circle number 2.

3. All KMC patients age 21 and under who come in for Well Child Check according to schedule list on reference sheet. Services provided under this category are billed to KMC, according to the reference sheet. (The reference sheet states what services are included. If other services are provided appropriate charges are made.)

4. All other children through ages 6 weeks to 6 years, who come in for Well Child Check according to reference sheet. Any health maintenance and curative services that are not included in the routine Well Child allowance are billed to the patient (e.g. drugs, special tests, EKG, x-ray). FNS gives free Well Child Check to children up to 6 years of age, if not covered by KMC or other third party payors. See reference sheet for services provided under "Well Child."

5. All employees coming in for routine annual physical are included (see reference sheet and employment policies for services included). If other services are provided, charges are made.



[illegible]
1 FAMILY PLANNING (KMC)
[✓ 2] LOW / HIGH RISK MCH
3 EARLY & PERIODIC SCREENING (KMC)
4 FNS CHILD HEALTH
5 ANNUAL EMPL. PHYS.
9 OTHER ____________ SPECIFY
0 NOT APPLICABLE

Note: 6 and 7 no longer apply.

9. Other - This is to be used when new special status programs are initiated.

0. This must be circled if none of the above are appropriate. This is important for keypunching.

SECTION XI: Nurse Visit:

Circle one code. At MBH the code is used to identify the type of nurse visit. (The charges remain the same for all categories.)

At District the code is used to identify type of nurse visit for charging purposes.

1. Routine initial - first visit

2. Routine follow-up - e.g. check chronically ill patient, allergy shot.

3. Extensive initial - e.g. complete history and physical exam done.

4. Extensive follow-up - e.g. post-op check, with complete history and physical.

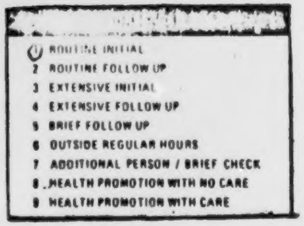
5. Brief follow-up - e.g. check use of medications, check healing of laceration.

6. Outside regular hours - no appointment, visit outside of scheduled clinic hours in District and at MBH.

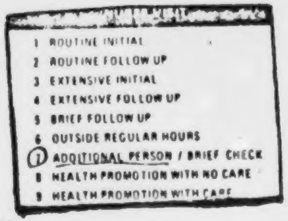
7. Additional person/brief check - purpose of visit for patient but e.g. other family member is checked and throat swab for streptococal infection is taken.

8. Health promotion no care - no preventive, therapeutic procedures undertaken.

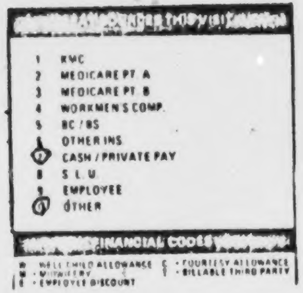
9. Health promotion with care - minimal services are rendered.



[✓ 1] ROUTINE INITIAL
2 ROUTINE FOLLOW UP
3 EXTENSIVE INITIAL
4 EXTENSIVE FOLLOW UP
5 BRIEF FOLLOW UP
6 OUTSIDE REGULAR HOURS
7 ADDITIONAL PERSON / BRIEF CHECK
8 HEALTH PROMOTION WITH NO CARE
9 HEALTH PROMOTION WITH CARE



1 ROUTINE INITIAL
2 ROUTINE FOLLOW UP
3 EXTENSIVE INITIAL
4 EXTENSIVE FOLLOW UP
5 BRIEF FOLLOW UP
6 OUTSIDE REGULAR HOURS
[✓ 7] ADDITIONAL PERSON / BRIEF CHECK
8 HEALTH PROMOTION WITH NO CARE
9 HEALTH PROMOTION WITH CARE



1 KMC
2 MEDICARE PT. A
3 MEDICARE PT. B
4 WORKMEN'S COMP.
5 BC / BS
6 OTHER INS
[✓ 7] CASH / PRIVATE PAY
8 S. L. U.
9 EMPLOYEE
[✓ 0] OTHER

FINANCIAL CODES

W · WELL CHILD ALLOWANCE
M · MIDWIFERY
E · EMPLOYEE DISCOUNT
C · COURTESY ALLOWANCE
T · BILLABLE THIRD PARTY

SECTION XII: Pay Sources This Visit:

Circle all pay sources for this visit, (there may be more than one).

If patient has a medical card, or any other type of insurance coverage, you must circle the pay source this visit.

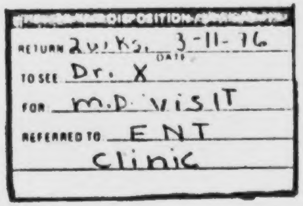
SECTION XIII: Financial Codes:

OMIT

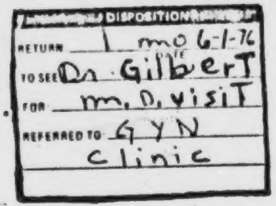
SECTION XIV: Disposition:

This is to be filled out by the provider upon completion of the visit. Appointment date is listed. All referrals must be noted. Accuracy is important because the information under Disposition goes into a tickler file.

At a District Clinic the file is monitored by a secretary who can check for what reason a person is coming for an appointment. Thus, if the patient does not have transportation, this can be planned in advance.



DISPOSITION
RETURN 2wks. 3-11-76 DATE
TO SEE Dr. X
FOR m.D visit
REFERRED TO ENT
clinic



DISPOSITION
RETURN 1 mo 6-1-76 DATE
TO SEE Dr. Gilbert
FOR m. D. visit
REFERRED TO GYN
clinic

SECTION XV: Type of Referral:

Three codes may be circled. This must be coded for all patients. A follow-up appointment is not a referral.

1. To be circled if no referrals are made.

2. This is for FNS referrals only. Refers to any patient that is referred to another FNS service, e.g. to dentist, Home Health, special clinic, or MBH.

3. This is for any agency or facility located in the county of residence of the patient.

4. This is for any agency or facility located in KRAD or Cumberland Valley District.

KRAD: Lee, Breathitt, Perry, Letcher, Wolfe, Knott, Leslie, Owsley

CVAD: Clay, Jackson, Laurel, Rockcastle, Harlan, Bell, Knox, Whitley

5. For any agency or facility outside KRAD but located within the Commonwealth of Kentucky.

6. For all out of State referrals e.g. Cincinnati, and the National Institute of Health in Washington.

SECTION XVI: Charges:

Charges are made for one or more procedures undertaken during a person's visit to a district clinic, home health visit, or MBH clinics. The E-Form is designed as a "record" of all items for which a patient is charged. In order to insure that the accurate charge is made, all diagnoses, tests, procedures, and medications must be properly labelled and coded. All charges must be listed on appropriate lines in the charges section. There are no exceptions. All charges are listed in the charge book.

Note that there is special reimbursement for:

#61 - Gyn (pelvics - procedure)

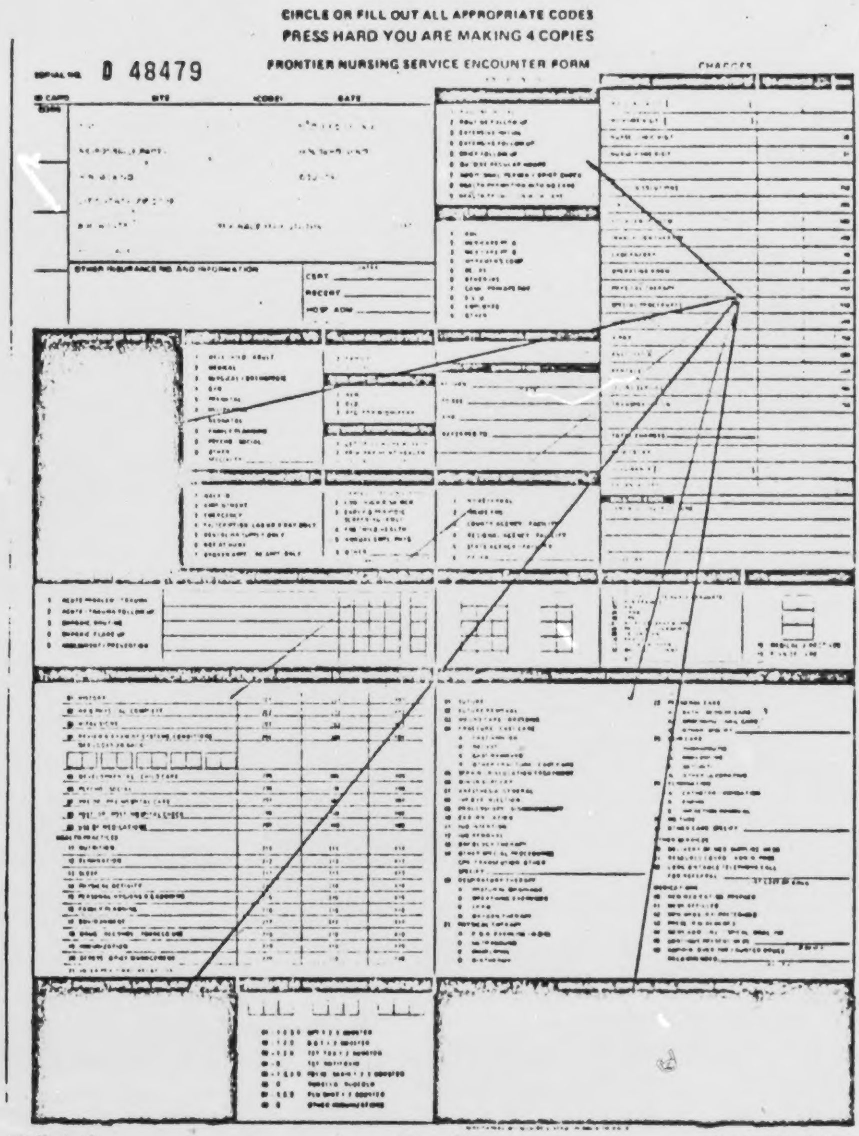
#69 - Family Planning and other special services and counseling.

There are special charges for:

#64 - Prenatal Initial - Registration

All Special Tests itemized, except P.P.D.'s* (Purified Protein Derivative), must be entered as laboratory charges. EKG and x-ray charges must be entered in their respective charge areas.

All drugs and solutions itemized under Medications, Supplies, Solutions, Rentals, etc: Drugs, solutions, supplies, and rental charges must be listed in their respective areas in the "Charges" section.



CIRCLE OR FILL OUT ALL APPROPRIATE CODES

PRESS HARD YOU ARE MAKING 4 COPIES

FRONTIER NURSING SERVICE ENCOUNTER FORM

D 48479

*Charged under Drugs

Mary Breckinridge Hospital:

Physicians are responsible for entering, under billing code, the code for the type of visit which is to be entered in the parenthesis. These are four digit codes for the type of procedures the M.D. would do during an encounter. The four digit numbers are based on Medicare and Medicaid fee schedules. Under code column they are to write their own ID code.

Cashiers at the front desk are responsible for entering all other charges according to the charge list, (double check to see that all charges coincide with services rendered).

The cashier must add up charges under Total Charges, then enter the amount covered by FNS allowance. This amount is deducted from total charges. The patients will then know what they owe for services provided. The cashier tells the patient what payment they are responsible for and what services third party will cover.

The amount actually paid for the visit is entered under Paid Today. The amount under allowance and paid today is then added and subtracted from Total Charge. The remainder is entered under Balance Left.*

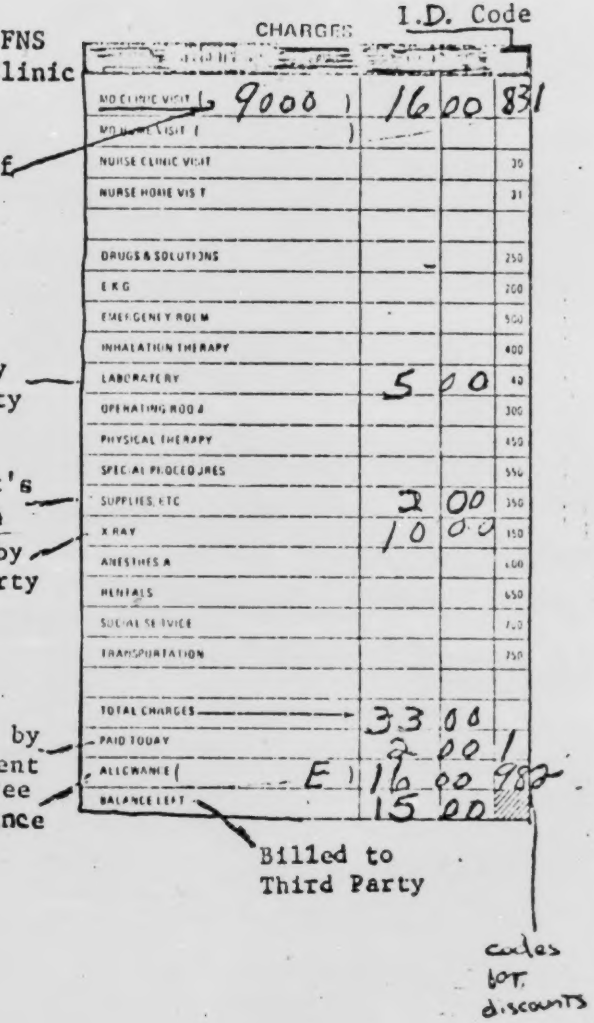
Beside paid today, under code, enter #1 if amount is actually paid. If not paid, leave blank.

Patients should know that they will receive a bill for the balance which may be changed after the Business Office checks the deductions for third party payors and other allowances.

*SAMPLE

An employee of FNS makes an M.D. Clinic visit.

Code for type of visit.



M.D. I.D. Code

CHARGES

MD CLINIC VISIT (9000)	16	00	831
MD HOME VISIT ( )			
NURSE CLINIC VISIT			30
NURSE HOME VISIT			31
DRUGS & SOLUTIONS			250
EKG			700
EMERGENCY ROOM			500
INHALATION THERAPY			400
LABORATORY	5	00	40
OPERATING ROOM			300
PHYSICAL THERAPY			450
SPECIAL PROCEDURES			550
SUPPLIES, ETC	2	00	350
X RAY	10	00	150
ANESTHESIA			600
RENTALS			650
SOCIAL SERVICE			[illegible]
TRANSPORTATION			750
TOTAL CHARGES	33	00	
PAID TODAY	2	00	1
ALLOWANCE (E)	16	00	982
BALANCE LEFT	15	00	

Covered by Third Party

Patient's expense

Covered by Third Party

Paid by Patient

Employee Allowance

Billed to Third Party

codes for discounts

District:

In District, all nurses are responsible for entering all charges for services rendered according to the charge list. On home visits, nurses must fill in all charges at the top.

1. Add total charges

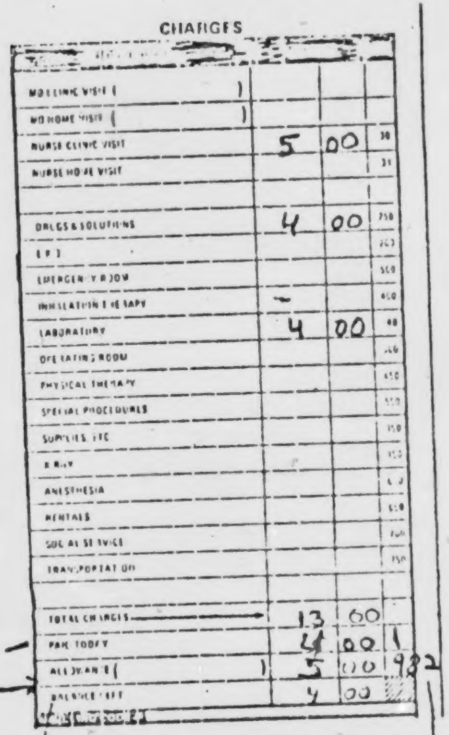
2. Enter amount paid today

Note: Any allowances or third party will be handled by the accounting office in the old hospital.

Any money paid on a previous balance must be entered on a receipt, not on the Encounter Form. If a patient is paying for a previous month's bill, the nurse or district secretary must ask for the top portion of the statement (from the computerized bill).

Note: District secretaries are responsible for checking the charges section before the E-Form is sent into the District Accounting Office.

SAMPLE:
FNS Employee!
Woman comes in for routine prenatal.



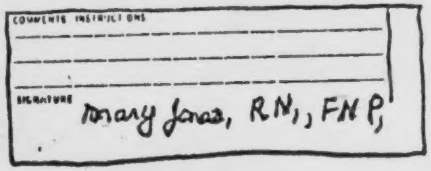
CHARGES

MD CLINIC VISIT ( )			
MD HOME VISIT ( )			
NURSE CLINIC VISIT	5	00	30
NURSE HOME VISIT			31
DRUGS & SOLUTIONS	4	00	250
EKG			260
EMERGENCY ROOM			500
INHALATION THERAPY	–		400
LABORATORY	4	00	40
OPERATING ROOM			360
PHYSICAL THERAPY			420
SPECIAL PROCEDURES			520
SUPPLIES ETC			250
X-RAY			150
ANESTHESIA			[illegible]
RENTALS			610
SOCIAL SERVICE			700
TRANSPORTATION			750
TOTAL CHARGES ——→	13	00	
PAID TODAY	4	00	1
ALLOWANCE ( )	5	00	932
BALANCE LEFT	4	00	

Patient Pays
Employee Allowance
Billed to Third Party
codes for discounts

SECTION XVII: Comments/Instructions and Signature:

Signature on the E-Form and patient's medical record must be the same; must be by the actual provider of the service.



COMMENTS INSTRUCTIONS

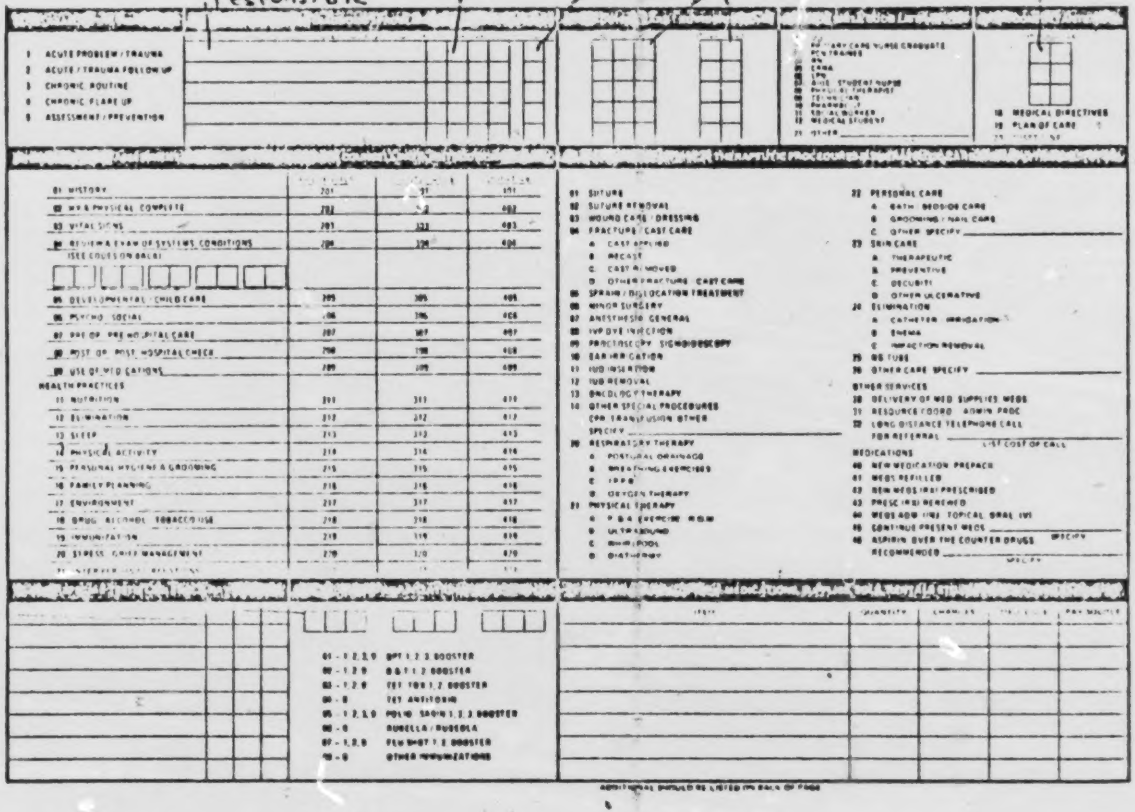
SIGNATURE Mary Jones, RN, FNP

BOTTOM SECTION:

This section tells us what was identified as a problem(s) and what was done. Elements of the POR system make up the bottom section of the Encounter Form.

The provider is responsible for filling in this section. The Encounter Form must coincide with the patients medical record, this is important for record audit.

The Encounter Form will give the third party payor a clear picture of what service was provided. This will help avoid unnecessary delays in reimbursement procedure. The E-Form must be filled out accurately and DURING THE CLINICAL ENCOUNTER. Under no circumstances should completion of this section be posponed to a later time.



Provider responsible

Secretary

Provider

Provider

Provider

Provider

Provider

Provider

Provider

Provider

[Secretary in District checks]

[Secretary in District checks]

1 ACUTE PROBLEM / TRAUMA
2 ACUTE / TRAUMA FOLLOW UP
3 CHRONIC ROUTINE
4 CHRONIC FLARE UP
5 ASSESSMENT / PREVENTION

[illegible] CARE NURSE GRADUATE
[illegible] TRAINEE
RN
CAMA
LPN
AIDE STUDENT NURSE
PHYSICAL THERAPIST
TECHNICIAN
PHARMACIST
SOCIAL WORKER
MEDICAL STUDENT
OTHER ________

18 MEDICAL DIRECTIVES
19 PLAN OF CARE
20 [illegible]

01 HISTORY	201	[illegible]	401
02 HX & PHYSICAL COMPLETE	202	[illegible]	402
03 VITAL SIGNS	203	303	403
04 REVIEW & EXAM OF SYSTEMS CONDITIONS (SEE CODES ON BACK)	204	304	404
05 DEVELOPMENTAL / CHILD CARE	205	305	405
06 PSYCHO SOCIAL	206	306	406
07 PRE OP. PRE HOSPITAL CARE	207	307	407
08 POST OP. POST HOSPITAL CHECK	208	308	408
09 USE OF MEDICATIONS	209	309	409
HEALTH PRACTICES			
11 NUTRITION	211	311	411
12 ELIMINATION	212	312	412
13 SLEEP	213	313	413
14 PHYSICAL ACTIVITY	214	314	414
15 PERSONAL HYGIENE & GROOMING	215	315	415
16 FAMILY PLANNING	216	316	416
17 ENVIRONMENT	217	317	417
18 DRUG ALCOHOL TOBACCO USE	218	318	418
19 IMMUNIZATION	219	319	419
20 STRESS GRIEF MANAGEMENT	220	320	420
21 [illegible]	[illegible]	[illegible]	[illegible]

THERAPEUTIC PROCEDURES

01 SUTURE
02 SUTURE REMOVAL
03 WOUND CARE / DRESSING
04 FRACTURE / CAST CARE
  A CAST APPLIED
  B RECAST
  C CAST REMOVED
  D OTHER FRACTURE CAST CARE
05 SPRAIN / DISLOCATION TREATMENT
06 MINOR SURGERY
07 ANESTHESIA GENERAL
08 IVP DYE INJECTION
09 PROCTOSCOPY SIGMOIDOSCOPY
10 EAR IRRIGATION
11 IUD INSERTION
12 IUD REMOVAL
13 ONCOLOGY THERAPY
14 OTHER SPECIAL PROCEDURES CPR TRANSFUSION OTHER SPECIFY ________
20 RESPIRATORY THERAPY
  A POSTURAL DRAINAGE
  B BREATHING EXERCISES
  C IPPB
  D OXYGEN THERAPY
21 PHYSICAL THERAPY
  A P & A EXERCISE ROM
  B ULTRASOUND
  C WHIRLPOOL
  D DIATHERMY
22 PERSONAL CARE
  A BATH BEDSIDE CARE
  B GROOMING / NAIL CARE
  C OTHER SPECIFY ________
23 SKIN CARE
  A THERAPEUTIC
  B PREVENTIVE
  C DECUBITI
  D OTHER ULCERATIVE
24 ELIMINATION
  A CATHETER IRRIGATION
  B ENEMA
  C IMPACTION REMOVAL
25 NG TUBE
26 OTHER CARE SPECIFY ________
OTHER SERVICES
30 DELIVERY OF MED SUPPLIES MEDS
31 RESOURCE COORD ADMIN PROC
32 LONG DISTANCE TELEPHONE CALL FOR REFERRAL ________ LIST COST OF CALL
MEDICATIONS
40 NEW MEDICATION PREPACK
41 MEDS REFILLED
42 NEW MEDS (RX) PRESCRIBED
43 PRESC (RX) RENEWED
44 MEDS ADM (RX) TOPICAL ORAL (IV)
45 CONTINUE PRESENT MEDS ________
46 ASPIRIN OVER THE COUNTER DRUGS RECOMMENDED ________ SPECIFY

01 - 1, 2, 3, 9 DPT 1, 2, 3 BOOSTER
02 - 1, 2, 9 D & T 1, 2 BOOSTER
03 - 1, 2, 9 TET TOX 1, 2 BOOSTER
04 - 9 TET ANTITOXIN
05 - 1, 2, 3, 9 POLIO SABIN 1, 2, 3 BOOSTER
06 - 0 RUBELLA / RUBEOLA
07 - 1, 2, 9 FLU SHOT 1, 2 BOOSTER
10 - 0 OTHER IMMUNIZATIONS

ITEM	QUANTITY	CHARGES	[illegible]	PAY SOURCE

ADDITIONAL SHOULD BE LISTED ON BACK OF FORM

SECTION XVIII: Reason for Visit:

Circle one code only.

1-4. This must be marked if an acute or chronic problem is coded under Diagnosis/Problem Assessed, or Managed Today. The reason is determined by the provider's assessment according to service provided.

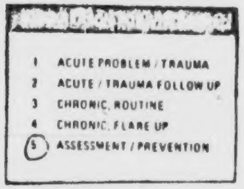
1. Acute Curative - Any acute problem, including follow-up care, requiring corrective measures if condition is not resolved (curative care).

2. Acute Maintenance - Any acute follow-up visit in which no corrective measure is required at the time of the visit, or in which the condition is stabilized or resolved (maintenance care).

3. Chronic Maintenance - Any chronic condition that is stabilized and requires no additional corrective measures (maintenance care). It may include continuing care of a stabilized condition, supportive care or reinforcement of prior instruction.

4. Chronic Curative - Any chronic condition including flare-ups or worsening of condition, requiring any corrective or skilled health care (alleviation of condition, pain, discomfort or distress. It involves all therapeutic care, counseling or teaching (curative care). It may be care following initial diagnosis until condition is fully stabilized, or care due to worsening of condition or terminal care.

   It patient has a stabilized chronic condition and a new chronic condition is identified, this number should be checked until the new chronic condition is fully stabilized.



[illegible]

1 ACUTE PROBLEM / TRAUMA
2 ACUTE / TRAUMA FOLLOW UP
3 CHRONIC, ROUTINE
4 CHRONIC, FLARE UP
[✓ 5] ASSESSMENT / PREVENTION

5. Assessment and Prevention - Any visit in which no acute or chronic condition (physical, social or mental) is identified or entered under Diagnosis/Problem Assessed today. This visit is limited to health assessment for preventive or health promotion purposes and preventive measures including teaching and counseling.

Immunization, prenatal, postpartum, neonatal, Well Child/Adult are considered preventive care. The same applies to Family Planning including dispensing of pills or contraceptives, vitamins or iron sulfate when they are given preventively in prenatal or well child care.

Note: A person who comes in with one or several chronic problems but whose reason for visit is an acute problem, is listed as an Acute Visit. A diabetic may come in with a laceration on the hand, in this case the primary reason for the visit is not the diabetes, but the laceration. Thus #1 is circled.

SECTION XIX: Diagnosis/Problem:

Procedure at MBH - All coding of diagnosis and problems are to be done by secretarial/clerical staff, as designated. The name of the diagnosis or problem is to be written in by the practitioner.

Procedures at District and Home Health - All practitioners are required to put down the Diagnosis or Problem in writing. Individual arrangements are made between practitioner and secretary as to who does the ICDA coding. However, the secretary is ultimately responsible to see that all codes are properly listed.

ICDA codes must be accurate for billing processing and credit purposes.

What to Write:

The Diagnosis/Problem is a combination of the persons "chief complaint" and the providers assessment.

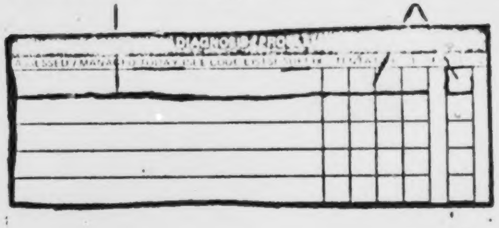
Only those problems reviewed during an encounter should be listed. If there are multiple problems, the problem corresponding to the reason for visit should be listed first.

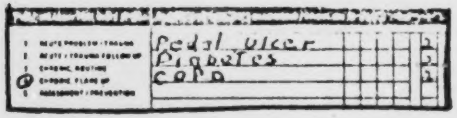
Examples:

1. A diabetic comes in with a laceration: Reason for visit is Acute/Trauma, Diagnosis/Problem is: 1. Laceration 2. Diabetes.
2. If a diabetic with COPD came in with a pedal ulcer, the reason for visit is Chronic Flare-up, Diagnosis/Problem is: 1. Pedal ulcer 2. Diabetes 3. COPD

NAME OF:
Problem reviewed or
Problem managed

ICDA Code

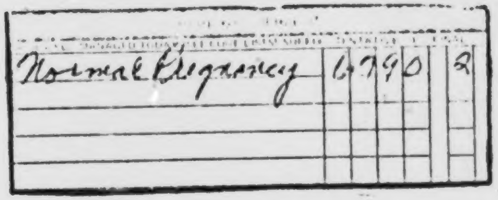

DIAGNOSIS/PROBLEM



Pedal ulcer
Diabetes
COPD

3. If a woman comes in for a prenatal visit but is discovered to be anemic, the reason for visit is Acute Problem, Diagnosis/Problem is: 1. Anemia 2. Pregnancy.

4. If a woman comes in for routine prenatal visit and nothing is wrong the reason for visit is Assessment/Prevention, Diagnosis/Problem is: Pregnancy - Normal.



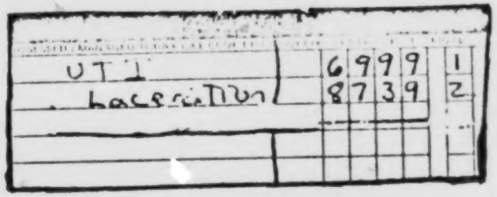
Normal Pregnancy	6	7	9	0	2

Note: Only in rare cases will a practitioner list more than five problems. If so, write additional problems on back of the Encounter Form.

Suffix: Note this is not a rule out section.

Suffix: Tentative = 1 should be used if diagnosis is uncertain and appropriate objective data (e.g. Lab reports) have not been obtained to verify diagnosis, e.g. UTI or Strep Throat.

Suffix: Final = 2 is used when diagnosis of condition is clearly evident or has been established and verified through lab tests. This suffix means diagnosis is complete.



UTI	6	9	9	9	1
Laceration	8	7	3	9	2

SECTION XX: Assessment:

Explanation of these sections will be divided into two parts. The first section explains what the categories under Assessment represent; the second illustrates when and how categories of preventive, maintenance and curative, under Counseling and Instruction, are applied.

A & B Condition of Patient (physical, mental, social & situational.

A. 01-04. This section refers essentially to physical assessment of person. One or more categories may be circled.

01. Routine history is taken for problem identified (does not include any physical exam).

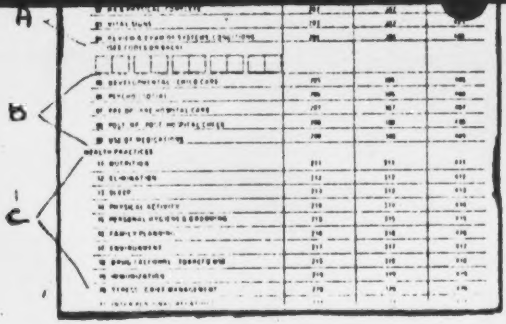
02. When a complete history and physical is done, this includes well-adult checks. If this category is circled, 01 and 03 need not be circled since these are already included under 02.

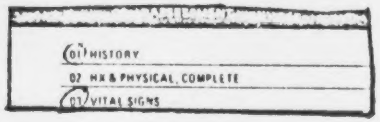
03. This is the minimum assessment done for all patients. 01 and 03 may be circled together.

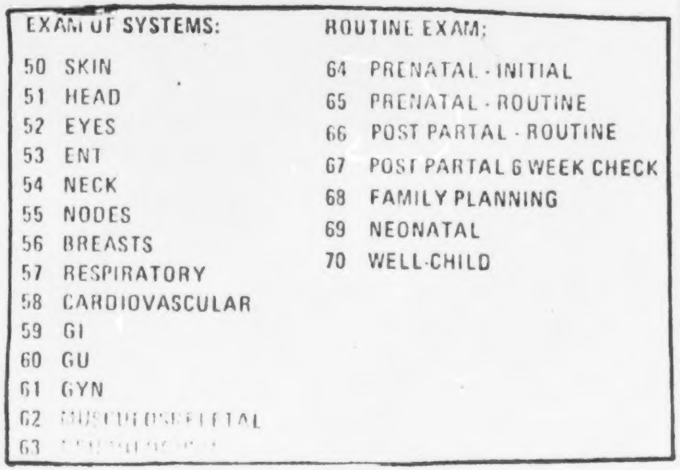
04. This refers to specific review of one or more systems or conditions when only a partial physical examination or special checks are done, e.g. prenatal. For every review and exam undertaken, enter a corresponding number, as listed on the back of the Encounter Form.

Example: A woman comes for initial prenatal visit and has a complete routine history and physical for prenatal care. She complains of a skin irritation and a special check of the skin is made. This should be coded.

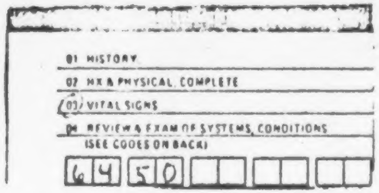
Note: Routine exams have rules, there are specific procedures and forms to be filled out.




[✓ 01] HISTORY
02 HX & PHYSICAL, COMPLETE
[✓ 03] VITAL SIGNS


EXAM OF SYSTEMS:
50 SKIN
51 HEAD
52 EYES
53 ENT
54 NECK
55 NODES
56 BREASTS
57 RESPIRATORY
58 CARDIOVASCULAR
59 GI
60 GU
61 GYN
62 MUSCULOSKELETAL
63 [illegible]

ROUTINE EXAM:
64 PRENATAL - INITIAL
65 PRENATAL - ROUTINE
66 POST PARTAL - ROUTINE
67 POST PARTAL 6 WEEK CHECK
68 FAMILY PLANNING
69 NEONATAL
70 WELL-CHILD


01 HISTORY
02 HX & PHYSICAL, COMPLETE
[✓ 03] VITAL SIGNS
04 REVIEW & EXAM OF SYSTEMS, CONDITIONS (SEE CODES ON BACK)
64 50

Under exam of systems are numbers 50 through 63. You should only review those systems which pertain to the problem for which the patient came to clinic, or which in the course of the check you found pertinent.

EXAMPLE:

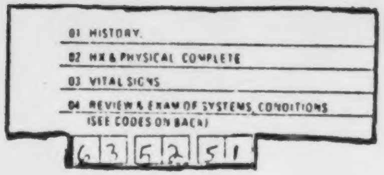
If a woman comes in for a head injury, the neurological system, the eyes and head, that is numbers 63, 52, and 51 may be listed. If a woman comes in for vaginitis you would review the Gyn or number 61. If a woman comes in for a Family Planning Clinic, Routine Exam would be marked, number 68. Procedures for physical exams under each routine exam are specified in the Medical Directives.

B. 05-09. One or more categories may be circled as they apply to respective problems listed under Diagnosis/Problem. This section refers essentially to situational or psych-social conditions of patient.

These should be marked if covered as part of the history and assessment of a patient. They are also marked if counseling or instruction that pertains to these categories is undertaken. (See appendix for further definitions)

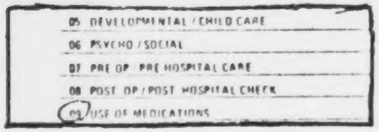
C. 11-21. Refers to Health Practice Assessment. One or more categories may be circled. This section refers to situational or routine health practices that are pertinent to problems or conditions identified by the provider or raised by the patient.

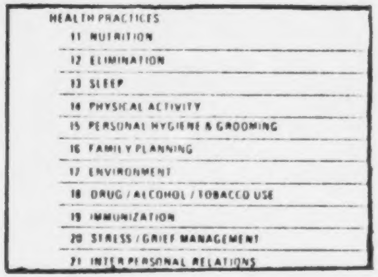
Note: For some cases no categories between 05-21 will be assessed.


01 HISTORY.
02 HX & PHYSICAL COMPLETE
03 VITAL SIGNS
04 REVIEW & EXAM OF SYSTEMS CONDITIONS
(SEE CODES ON BACK)
63 52 51

Example

In the same prenatal visit the midwife reviews what medicines the women is currently using.


05 DEVELOPMENTAL / CHILD CARE
06 PSYCHO / SOCIAL
07 PRE OP / PRE HOSPITAL CARE
08 POST OP / POST HOSPITAL CHECK
[✓ 09] USE OF MEDICATIONS


HEALTH PRACTICES
11 NUTRITION
12 ELIMINATION
13 SLEEP
14 PHYSICAL ACTIVITY
15 PERSONAL HYGIENE & GROOMING
16 FAMILY PLANNING
17 ENVIRONMENT
18 DRUG / ALCOHOL / TOBACCO USE
19 IMMUNIZATION
20 STRESS / GRIEF MANAGEMENT
21 INTERPERSONAL RELATIONS

Although a practitioner may cover certain categories for assessment, they will not necessarily do any counseling and instruction. Assessment, Counseling and Instruction are two separate sections. They integrate into one section when any counseling or instruction is undertaken for any

EXAMPLES:

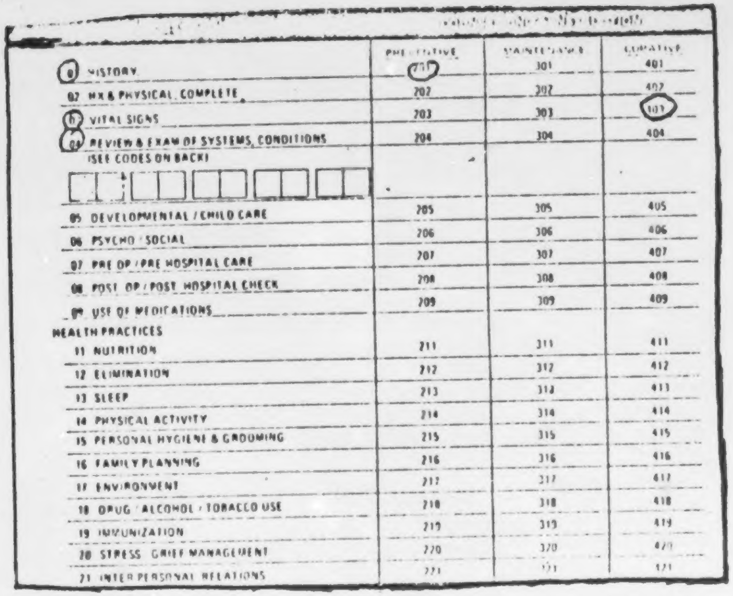
1. In some cases a practitioner would include teaching as part of the physical assessment. A hypertensive patient comes in for a chronic follow-up, the practitioner checks under vital signs, the blood pressure, which registers above normal. If the practitioner explains the need to lower the blood pressure, 403 would be circled because counseling was for curative-therapeutic reasons.

2. A family nurse takes a history of body functions that are within normal range and explains the importance of maintaining normal body functions to prevent any illness - 201 would be circled.

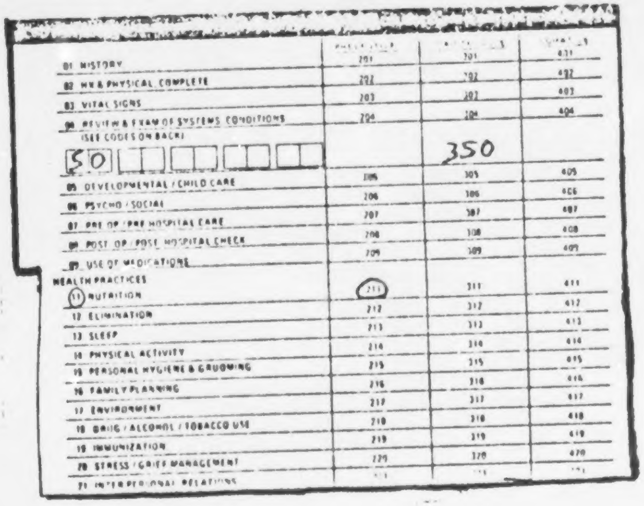
3. During a routine exam of a diabetic, with a newly healed pedal ulcer, a practitioner examines a specific system, e.g. skin. The practitioner explains the importance of keeping skin clean to maintain stable condition. Under assessment 50 would be written in box, under maintenance 350 would be written in.

4. For the same diabetic, the practitioner may assess nutritional practices. The patient has followed prescribed diet and has maintained normal range of FBS and further counseling and instruction is reinforced. Under Counseling and Instruction 311 would be circled. The practitioner may also counsel on the importance of eating certain foods in order to prevent excessive weight gain, 211 could also be circled.

5. During a well child check, the practitioner talks to the mother about the importance of measles vaccine to help prevent measles, 219 is circled. Whatever counseling and instruction that is done must correspond to what is written under Diagnosis/Problem.



	PREVENTIVE	MAINTENANCE	CURATIVE
[✓ 01] HISTORY	[✓ 201]	301	401
02 HX & PHYSICAL COMPLETE	202	302	402
[✓ 03] VITAL SIGNS	203	303	[✓ 403]
[✓ 04] REVIEW & EXAM OF SYSTEMS, CONDITIONS (SEE CODES ON BACK)	204	304	404
05 DEVELOPMENTAL / CHILD CARE	205	305	405
06 PSYCHO / SOCIAL	206	306	406
07 PRE OP / PRE HOSPITAL CARE	207	307	407
08 POST OP / POST HOSPITAL CHECK	208	308	408
09 USE OF MEDICATIONS	209	309	409
HEALTH PRACTICES			
11 NUTRITION	211	311	411
12 ELIMINATION	212	312	412
13 SLEEP	213	313	413
14 PHYSICAL ACTIVITY	214	314	414
15 PERSONAL HYGIENE & GROOMING	215	315	415
16 FAMILY PLANNING	216	316	416
17 ENVIRONMENT	217	317	417
18 DRUG / ALCOHOL / TOBACCO USE	218	318	418
19 IMMUNIZATION	219	319	419
20 STRESS / GRIEF MANAGEMENT	220	320	420
21 INTER PERSONAL RELATIONS	221	321	421



	[illegible]	[illegible]	[illegible]
01 HISTORY	201	301	401
02 HX & PHYSICAL COMPLETE	202	302	402
03 VITAL SIGNS	203	303	403
04 REVIEW & EXAM OF SYSTEMS CONDITIONS (SEE CODES ON BACK)	204	304	404
50		350	
05 DEVELOPMENTAL / CHILD CARE	205	305	405
06 PSYCHO / SOCIAL	206	306	406
07 PRE OP / PRE HOSPITAL CARE	207	307	407
08 POST OP / POST HOSPITAL CHECK	208	308	408
09 USE OF MEDICATIONS	209	309	409
HEALTH PRACTICES			
[✓ 11] NUTRITION	[✓ 211]	311	411
12 ELIMINATION	212	312	412
13 SLEEP	213	313	413
14 PHYSICAL ACTIVITY	214	314	414
15 PERSONAL HYGIENE & GROOMING	215	315	415
16 FAMILY PLANNING	216	316	416
17 ENVIRONMENT	217	317	417
18 DRUG / ALCOHOL / TOBACCO USE	218	318	418
19 IMMUNIZATION	219	319	419
20 STRESS / GRIEF MANAGEMENT	220	320	420
21 INTER PERSONAL RELATIONS	[illegible]	[illegible]	[illegible]

Section XXI : Counseling and Instruction

This section is important:

1. As a record for what health teaching took place e.g. does the health teaching correspond with what is written in the medical record under Plan;
2. For education of patient and practitioner.
3. For potential reimbursement purposes.

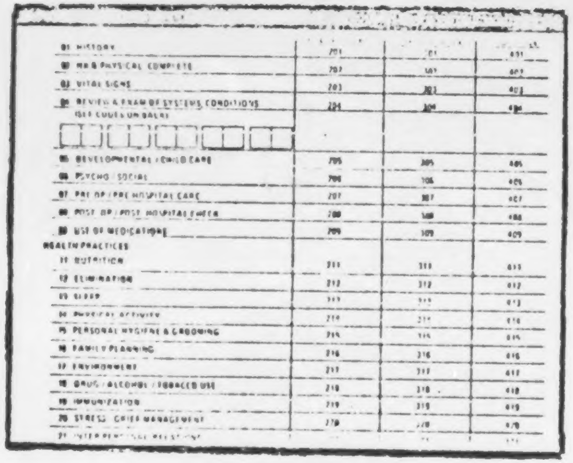
At this time we are trying to record how much output in counseling and instruction is taking place in order to demonstrate type of instruction and frequency. In the future this may have implications for reimbursement through third party payors.

Counseling and Instruction is divided into three sections: Preventive, Maintenance and Curative.

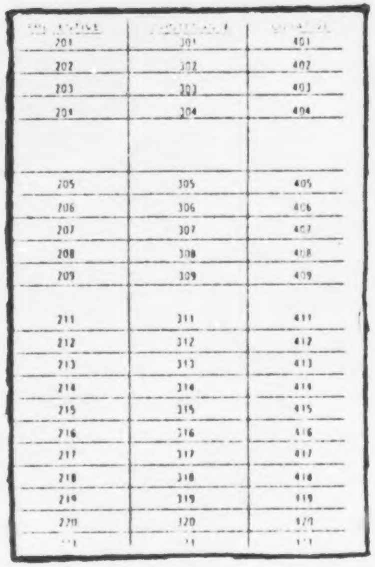
Depending upon the problem(s) and category assessed, one or two sections may be circled. Thus for some problems and under specific categories both preventive and curative teaching may be undertaken.

1. Preventive - Code 200 numbers e.g. this may include preventive instruction after the condition is resolved.
2. Health Maintenance - Code 300 numbers, this includes reinforcement of current health practices or instruction about health practices in order to retain status quo of physical, mental, social situation.
3. Curative (Therapeutic) - Code 400 numbers. For corrective counseling instruction or support given for the problem managed as coded above.

Note: Use of 200, 300, or 400 codes for Counseling and Instruction must correspond with reason for visit and for types of diagnoses or problem.



01 HISTORY	201	301	401
02 HX & PHYSICAL COMPLETE	202	302	402
03 VITAL SIGNS	203	303	403
04 REVIEW & EXAM OF SYSTEMS CONDITIONS (SEE CODES ON BACK)	204	304	404
☐☐☐☐☐☐☐☐☐☐			
05 DEVELOPMENTAL / CHILD CARE	205	305	405
06 PSYCHO / SOCIAL	206	306	406
07 PRE OP / PRE HOSPITAL CARE	207	307	407
08 POST OP / POST HOSPITAL CHECK	208	308	408
09 USE OF MEDICATIONS	209	309	409
HEALTH PRACTICES			
11 NUTRITION	211	311	411
12 ELIMINATION	212	312	412
13 SLEEP	213	313	413
14 PHYSICAL ACTIVITY	214	314	414
15 PERSONAL HYGIENE & GROOMING	215	315	415
16 FAMILY PLANNING	216	316	416
17 ENVIRONMENT	217	317	417
18 DRUG / ALCOHOL / TOBACCO USE	218	318	418
19 IMMUNIZATION	219	319	419
20 STRESS / GRIEF MANAGEMENT	220	320	420
21 INTERPERSONAL RELATIONS	[illegible]	[illegible]	[illegible]



PREVENTIVE	MAINTENANCE	CURATIVE
201	301	401
202	302	402
203	303	403
204	304	404
205	305	405
206	306	406
207	307	407
208	308	408
209	309	409
211	311	411
212	312	412
213	313	413
214	314	414
215	315	415
216	316	416
217	317	417
218	318	418
219	319	419
220	320	420
[illegible]	[illegible]	[illegible]

Thus:

For Preventive/Assessment there would be no need for maintenance or curative counseling, (300's or 400's).

For acute follow-up or chronic routine visits, e.g. maintenance, there would be no curative, (400) counseling. Preventive may be done.

For acute or chronic flare-up visits, preventive

SECTION XXII: Special Tests, Lab, EKG, X-ray:

Any lab test, EKG, or x-ray order, to be performed at the MBH, (or District) must be entered.

The name of the lab test must specify the exact test (e.g. dipstick or micro, not "urinalysis"). The corresponding code (see reference sheet in appendix) must be entered beside the name of the test.

Physicians and nurses are responsible for completing name and code. Charges are made according to name and code. These must be correct for billing.

X-ray, EKG and Physical Therapy do their own coding.

District:

B-Form - Any lab specimen that is sent to MBH must be accompanied by a B-Form. The B-Form is essential for third party reimbursement. (The codes for all tests are entered by the nurse but are checked by the secretary.) Lab tests ordered, without samples, are entered by lab personnel when performed.

No EKG or x-ray procedures are performed in District, although the nurse or physician may order them. These are entered on the E-Form by EKG or x-ray personnel when performed.

Lab work performed in District is not reimbursed through third party, even if a physician is present. Therefore, all Lab work done in District must be private pay.

"Nurse visit" charge is made if a e.g. blood sample is collected in a home.

XXIII: Immunizations:

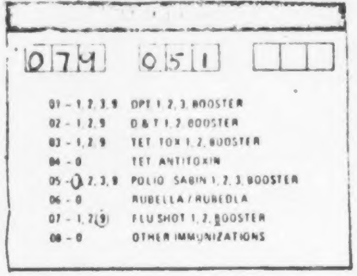
Beside the numbers 01 - 08 are a series of numbers: 1, 2, 3, and 9, accompanied by the name of the immunization. You are to include in the box, 3 numbers, the 01, the 02, the 03 plus one of the four corresponding numbers.

It is important that this section be filled out accurately. The Leslie County Health Department receives all reports from the FNS on immunizations given. On the basis of these reports the FNS pharmacy receives a corresponding supply of drugs based on the number of immunizations reported from the FNS.

Note: For other immunizations code 080 e.g. the Swine Flu vaccine. Specify medications and itemize these under Medication, Supplies, Sols, Rentals, etc. section. (This would include allergy immunizations.)

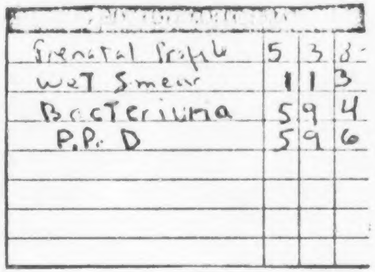
Example:

Flu shot booster.
Polio Sabin



0 7 9 0 5 1

01 - 1, 2, 3, 9 DPT 1, 2, 3, BOOSTER
02 - 1, 2, 9 D & T 1, 2 BOOSTER
03 - 1, 2, 9 TET TOX 1, 2, BOOSTER
04 - 0 TET ANTITOXIN
05 - 1, 2, 3, 9 POLIO SABIN 1, 2, 3, BOOSTER
06 - 0 RUBELLA / RUBEOLA
07 - 1, 2, 9 FLU SHOT 1, 2, BOOSTER
08 - 0 OTHER IMMUNIZATIONS



General Profile	5	3	8
Wet Smear	1	1	3
Bacteriuria	5	9	4
P.P. D	5	9	6

SECTI XXIV: Therapeutic Procedures & Therapeutic Care:

Code all services provided. The procedures must correspond to the problems or conditions listed under Diagnosis/Problem. 01-26 are self-explanatory. Where A, B, C, D are listed, circle both the code number and the alphabetical letter.

14 - A pelvic exam must be written in under other special procedures. This is important for reimbursement purposes.

26 - Other care specify - itemize what care was given and all supplies used.

30 - If medical supplies or medications are issued, or delivered without providing care. Be sure to itemize them below.

31 - Any resource coordination or administrative procedure used in the provision of health/social care (e.g. excuse letters for school, referrals, legal or administrative procedures relating to a patients state of health). This includes arranging for assistance with other agencies e.g. health or social services.

32 - List the cost of long distance calls made in the care of a patient, (e.g. consultation, referral, coordination or administration). Calls can be charged only if made in presence of the patient.

In the hospital, ask the operator to make the call and give name of patient and time charge to cashier. This is to be entered on the E-Form.

In District, ask the long distance operator for time charge when call is placed. Enter the charge on the E-Form.

40-44. Medications or prescriptions given must be appropriately coded and listed below under Medication, Supplies, Sols, Rentals, etc. This includes quantity, charges, medical code and pay source.

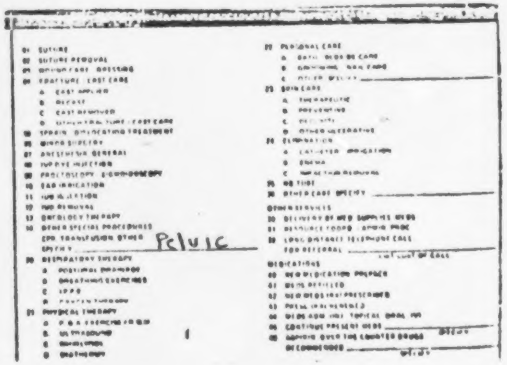
45. Write the medications the patient continues to use.

Note: At the bottom of the page under charges, "Prescription only" must be written in though it can be filled anywhere e.g. any pharmacy. No charges are entered under "Charges" section.

If a FNS prepackaged drug is given, quantity and charge and pay source are listed. Third party payors will cover certain types of drugs, refer to the white card. (See appendices)

For KMC, if prepackaged drugs are given: Do not enter under the "Charges" at the top of the page. KMC charges are made by Pharmacy.

Private Pay Patients: The total cost of all prepackaged drugs are entered in the "Charges" section. Please note these variations.



SECTION XXV: Medications, Supplies, Sol. Rentals, Etc:

All medications, supplies, solutions or rentals prescribed and issued must be listed. In order for cashiers to make proper charges, the item must bear the names used at the FNS and which appear in the corresponding FNS charge book.

Medications - Under "item" write name; quantity, e.g. how many c.c.'s or m.g.'s; charges write R_x if only a prescription is written.

If prepackaged medication is given, (as in District or ER) leave pay source blank. Pay source is filled out by the Cashier.

If a patient is KMC, (look at "Pay Sources This Visit) the claim number must be written on the prescription form. (See I.D. information for E-Form, Section II.)

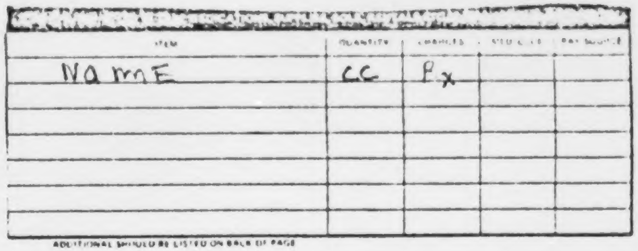
Home Health - If medications are purchased and brought out to a person, itemize name of medication, charges, R_x. The person must pay cash on delivery, unless they have KMC.

Under pay source, all numbers are given a prefix "0". The Home Health Intake Secretary is responsible for writing in the pay source code, e.g. 01 = KMC.

Supplies and Solutions - The name of item, quantity, charges and pay source must be filled in as for medications above.

For District, all supplies, regardless of pay source, are billed from the District Accounting Office in the old hospital.

The back of the E-Form can be used if additional space is needed to list medications, etc.



ITEM	QUANTITY	CHARGES	[illegible]	PAY SOURCE
Name	cc	Rx		

ADDITIONAL SHOULD BE LISTED ON BACK OF PAGE

SECTION XXVI: Direct Care Providers:

All direct care providers must code their individual provider number. These are issued by the key punch operator. Use code numbers as issued.

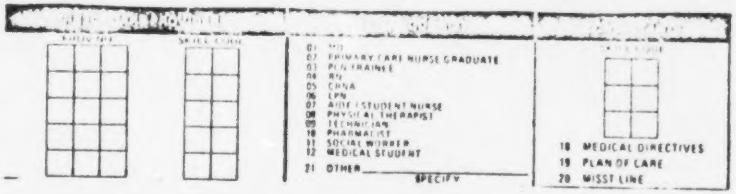
Note: 13 - Dentist - New skill number.

There may be more than one direct care provider, e.g. FN plus M.D.

SECTION XXVII: Consultants:

Identify all consultation used by the skill code number of person consulted or codes 18-20.

20 - Misst Line is a special consultation call made to the UK Medical Center or the Medical Center in Louisville.



01 MD
02 PRIMARY CARE NURSE GRADUATE
03 PCN TRAINEE
04 RN
05 CRNA
06 LPN
07 AIDE / STUDENT NURSE
08 PHYSICAL THERAPIST
09 TECHNICIAN
10 PHARMACIST
11 SOCIAL WORKER
12 MEDICAL STUDENT
21 OTHER ____ SPECIFY

18 MEDICAL DIRECTIVES
19 PLAN OF CARE
20 MISST LINE

I. SAMPLE ENCOUNTER FORMS

The following Encounter Forms have been filled our correctly.

Sample A: HOME HEALTH - Patient with multiple chronic problems.

Sample B: DISTRICT CLINIC - Prenatal patient with acute problem.

Sample C: MARY BRECKINRIDGE HOSPITAL - "MTD" prenatal patient - routine.

Sample D: MARY BRECKINRIDGE HOSPITAL - Patient with multiple acute problems.

II. Sample of Fee Schedules for "Home" and District Clinics, Explanation of Nurse Visit categories.

III. Explanation of Midwifery Charges for District

IV. Sample of "White Card" showing third party coverage by service.

V. Sample of Diagnostic List (H-ICDA-Second Edition) used at the FNS.

VI. Sample of Lab Code Reference Sheet used at the FNS.

SITE 25 (CODE) C/ DATE 11-1-76

CODE

NAME Jones, mary
MED RECORD # 64001
RESPONSIBLE PARTY Jones, Henry
HOUSEHOLD # 64-0007
ADDRESS Rt #3 · Box126
COUNTY 066
CITY, STATE, ZIP, PHONE Hyden, Ky 41749
BIRTHDATE 01-07-06
SEX RACE MAR STATUS 2-1-2
LOC 1
MED CARE # 030-03-603 0 A

OTHER INSURANCE NO. AND INFORMATION
Kmc
61-01364 2939

DATES
CERT. ___
RECERT. 10-03-76
HOSP. ADM. ___
HOSP. DIS. ___

1 ROUTINE INITIAL
[✓ 2 ROUTINE FOLLOW-UP]
3 EXTENSIVE INITIAL
4 EXTENSIVE FOLLOW-UP
5 BRIEF FOLLOW UP
6 OUTSIDE REGULAR HOURS
7 ADDITIONAL PERSON / BRIEF CHECK
8 HEALTH PROMOTION WITH NO CARE
9 HEALTH PROMOTION WITH CARE

1 KMC
2 MEDICARE PT. A
[✓ 3 MEDICARE PT. B]
4 WORKMEN'S COMP
5 BC / BS
6 OTHER INS.
7 CASH / PRIVATE PAY
8 S. L. U.
9 EMPLOYEE
0 OTHER

FINANCIAL CODE

MD CLINIC VISIT ( )			
MD HOME VISIT ( )			
NURSE CLINIC VISIT			33
NURSE HOME VISIT	24	00	11
DRUGS & SOLUTIONS	6	00	250
E K G			730
EMERGENCY ROOM			530
INHALATION THERAPY			400
LABORATORY			46
OPERATING ROOM			300
PHYSICAL THERAPY			452
SPECIAL PROCEDURES			552
SUPPLIES, ETC.			352
X RAY			150
ANESTHESIA			[illegible]
RENTALS			652
SOCIAL SERVICE			720
TRANSPORTATION			750
TOTAL CHARGES →	30	00	
PAID TODAY	5	00	
ALLOWANCE ( )			
BALANCE LEFT			▨

BILLING CODE

COMMENTS / INSTRUCTIONS

SIGNATURE Sally H. Smith, R.N.

DISTRICTS
[✓ PATIENT HOME]
NURSE CLINIC
SPECIAL CLINIC ___ SPECIFY
SIDE OF ROAD, OTHER
HOSPITAL:
GENERAL CLINIC
MTD CLINIC
PEDS CLINIC
GYN CLINIC
HEALTH ASSESSMENT CLINIC
ORTHOPEDIC CLINIC
NEUROLOGY CLINIC
OPHTHALMOLOGY CLINIC
OTHER SPECIAL CLINIC ___ SPECIFY
EMERGENCY ROOM
OTHER:
SOCIAL SERVICE
TRANSPORTATION MILEAGE ___

1 WELL CHILD / ADULT
[✓ 2 MEDICAL]
3 SURGICAL / ORTHOPEDIC
4 GYN
5 PRENATAL
6 POSTPARTAL
7 NEONATAL
8 FAMILY PLANNING
9 PSYCHO / SOCIAL
0 OTHER SPECIALTY ___

[✓ 1 INDIVIDUAL]
2 FAMILY
3 ANIMAL

1 NEW
[✓ 2 OLD]
3 REG. FOR MIDWIFERY

[✓ 1 CERTIFIED HOME HEALTH]
2 PRIV. PAY HOME HEALTH
3 OTHER HOME VISIT

RETURN: 11-15-76
DATE
TO SEE: ✓
FOR: Routine H.H.
REFERRED TO: Visit

1 WALK-IN
[✓ 2 APPOINTMENT]
3 EMERGENCY
4 PRESCRIPTION, LAB OR X RAY ONLY
5 RENTAL OR SUPPLY ONLY
6 NOT AT HOME
7 BROKEN APPT. / RE-APPT. ONLY

1 FAMILY PLANNING (KMC)
2 LOW / HIGH RISK MCH
3 EARLY & PERIODIC SCREENING (KMC)
4 FNS CHILD HEALTH
5 ANNUAL EMPL. PHYS.
9 OTHER ___ SPECIFY
[✓ 0 NOT APPLICABLE]

[✓ 1 NO REFERRAL]
2 INSIDE FNS
3 COUNTY AGENCY / FACILITY
4 REGIONAL AGENCY / FACILITY
5 STATE AGENCY / FACILITY
6 OTHER ___

ACUTE PROBLEM / TRAUMA
ACUTE / TRAUMA FOLLOW UP
[✓ CHRONIC, ROUTINE]
CHRONIC, FLARE UP
ASSESSMENT / PREVENTION

A S H D	4	1	2	9	2
C H F	4	2	7	0	2
Diabetes	2	5	0	0	2
Neurodermatitis	6	9	3	3	2

0 0 0

0 4

01 MD
02 PRIMARY CARE NURSE GRADUATE
03 PCN TRAINEE
04 RN
05 CRNA
06 LPN
07 AIDE / STUDENT NURSE
08 PHYSICAL THERAPIST
09 TECHNICIAN
10 PHARMACIST
11 SOCIAL WORKER
12 MEDICAL STUDENT
21 OTHER ___

1

18 MEDICAL DIRECTIVES
19 PLAN OF CARE
20 MISSED LINE

	PREVENTIVE	MAINTENANCE	CURATIVE
[✓ 01 HISTORY]	201	301	401
02 HX & PHYSICAL, COMPLETE	202	302	402
[✓ 03 VITAL SIGNS]	203	303	403
04 REVIEW & EXAM OF SYSTEMS, CONDITIONS (SEE CODES ON BACK)	204	304	404
57 55		358	
05 DEVELOPMENTAL / CHILD CARE	205	305	405
06 PSYCHO / SOCIAL	206	306	406
07 PRE OP / PRE HOSPITAL CARE	207	307	407
08 POST OP / POST HOSPITAL CHECK	208	308	408
[✓ 09 USE OF MEDICATIONS]	209	[✓ 309]	409
HEALTH PRACTICES			
[✓ 11 NUTRITION]	211	311	[✓ 411]
12 ELIMINATION	212	312	412
13 SLEEP	213	313	413
14 PHYSICAL ACTIVITY	214	314	414
[✓ 15 PERSONAL HYGIENE & GROOMING]	215	[✓ 315]	415
16 FAMILY PLANNING	216	316	416
17 ENVIRONMENT	217	317	417
18 DRUG / ALCOHOL / TOBACCO USE	218	318	418
[✓ 19 IMMUNIZATION]	[✓ 219]	319	419
20 STRESS / GRIEF MANAGEMENT	220	320	420
21 INTERPERSONAL RELATIONS	221	321	421

01 SUTURE
02 SUTURE REMOVAL
03 WOUND CARE / DRESSING
04 FRACTURE / CAST CARE
  A. CAST APPLIED
  B. RECAST
  C. CAST REMOVED
  D. OTHER FRACTURE / CAST CARE
05 SPRAIN / DISLOCATION TREATMENT
06 MINOR SURGERY
07 ANESTHESIA, GENERAL
08 IVP DYE INJECTION
09 PROCTOSCOPY / SIGMOIDOSCOPY
10 EAR IRRIGATION
11 IUD INSERTION
12 IUD REMOVAL
13 ONCOLOGY THERAPY
14 OTHER SPECIAL PROCEDURES CPR, TRANSFUSION, OTHER SPECIFY ___
20 RESPIRATORY THERAPY
  A. POSTURAL DRAINAGE
  B. BREATHING EXERCISES
  C. I P P B
  D. OXYGEN THERAPY
21 PHYSICAL THERAPY
  A. P & A EXERCISE - R O M
  B. ULTRASOUND
  C. WHIRLPOOL
  D. DIATHERMY
22 PERSONAL CARE
  A. BATH / BEDSIDE CARE
  B. GROOMING / NAIL CARE
  C. OTHER, SPECIFY ___
23 SKIN CARE
  A. THERAPEUTIC
  B. PREVENTIVE
  C. DECUBITI
  D. OTHER ULCERATIVE
24 ELIMINATION
  A. CATHETER / IRRIGATION
  B. ENEMA
  C. IMPACTION REMOVAL
25 NG TUBE
26 OTHER CARE, SPECIFY ___
OTHER SERVICES
30 DELIVERY OF MED. SUPPLIES, MEDS
[✓ 31 RESOURCE COORD. / ADMIN. PROC.]
32 LONG DISTANCE TELEPHONE CALL FOR REFERRAL ___ LIST COST OF CALL
MEDICATIONS
40 NEW MEDICATION, PREPACK
41 MEDS REFILLED
42 NEW MEDS (RX) PRESCRIBED
43 PRESC (RX) RENEWED
[✓ 44 MEDS ADM. (INJ., TOPICAL, ORAL, IV)]
45 CONTINUE PRESENT MEDS ___
46 ASPIRIN, OVER THE COUNTER DRUGS RECOMMENDED ___ SPECIFY

FBS	3	9	5
([illegible] form to			
MBH Lab)			

0 7 9

01 - 1, 2, 3, 9 DPT 1, 2, 3, BOOSTER
02 - 1, 2, 9 D & T 1, 2, BOOSTER
03 - 1, 2, 9 TET. TOX 1, 2, BOOSTER
04 - 0 TET. ANTITOXIN
05 - 1, 2, 3, 9 POLIO SABIN 1, 2, 3, BOOSTER
06 - 0 RUBELLA / RUBEOLA
[✓ 07] - 1, 2, 9 [illegible] 1, 2, BOOSTER
08 - 0 IMMUNIZATIONS

467

ITEM	QUANTITY	CHARGES	MED CODE	PAY SOURCE
Oretic 50 mg Tab				
Oretic 50 mg Tab	60			01
[Kmc will pay for				
This med Through				
MBH Pharmacy]				
Furacin Vag	1 oz.	4.00		07
Fluogen .05 cc	1	2.00		07

ADDITIONAL [illegible] BACK OF PAGE

DATE [illegible]

NAME Jones, mary
MED. RECORD NO. 64-0321
RESPONSIBLE PARTY Jones, Harry
HOUSEHOLD NO. 64-0322
R.R., BOX NO. RT 1, Box 123
COUNTY 066
CITY, STATE, ZIP CODE Hyden, Ky. 41749
BIRTHDATE 01-07-48
SEX, RACE, MAR. STATUS 2-1-2
LOC. .1
MEDICARE NO.

OTHER INSURANCE NO. AND INFORMATION
Kmc
12-3456789012

DATES
CERT. ____
RECERT. ____
HOSP. ADM. ____
HOSP. DIS. ____

1 ROUTINE INITIAL
[✓ 2 ROUTINE FOLLOW-UP]
3 EXTENSIVE INITIAL
4 EXTENSIVE FOLLOW-UP
5 BRIEF FOLLOW-UP
6 OUTSIDE REGULAR HOURS
7 ADDITIONAL PERSON / BRIEF CHECK
8 HEALTH PROMOTION WITH NO CARE
9 HEALTH PROMOTION WITH CARE

[✓ 1 KMC]
2 MEDICARE PT. A
3 MEDICARE PT. B
4 WORKMEN'S COMP.
5 BC / BS
6 OTHER INS.
[✓ 7 CASH / PRIVATE PAY]
8 S.L.U.
9 EMPLOYEE
0 OTHER

NO CLINIC VISIT ( )			
NO HOME VISIT ( )			
NURSE CLINIC VISIT	5	00	30
NURSE HOME VISIT			31
DRUGS & SOLUTIONS	1	00	250
E.K.G.			700
EMERGENCY ROOM			500
INHALATION THERAPY			400
LABORATORY	6	00	90
OPERATING ROOM			300
PHYSICAL THERAPY			450
SPECIAL PROCEDURES			550
SUPPLIES, ETC.			350
X RAY			150
ANESTHESIA			600
RENTALS			650
SOCIAL SERVICE			700
TRANSPORTATION			750
TOTAL CHARGES	12	00	
PAID TODAY	3	00	
ALLOWANCE ( )			
BALANCE LEFT			

CONTACTS:
PATIENT HOME
[✓ NURSE CLINIC]
SPECIAL CLINIC ____ SPECIFY
SIDE OF ROAD, OTHER
HOSPITAL:
GENERAL CLINIC
MTD CLINIC
PEDS CLINIC
GYN CLINIC
HEALTH ASSESSMENT CLINIC
ORTHOPEDIC CLINIC
NEUROLOGY CLINIC
OPHTHALMOLOGY CLINIC
OTHER SPECIAL CLINIC ____ SPECIFY
EMERGENCY ROOM
OTHER:
SOCIAL SERVICE
TRANSPORTATION MILEAGE ____

1 WELL CHILD / ADULT
2 MEDICAL
3 SURGICAL / ORTHOPEDIC
4 GYN
[✓ 5 PRENATAL]
6 POSTPARTAL
7 NEONATAL
8 FAMILY PLANNING
9 PSYCHO / SOCIAL
0 OTHER SPECIALTY ____

1 INDIVIDUAL
2 FAMILY
3 ANIMAL

1 NEW
[✓ 2 OLD]
3 REG. FOR MIDWIFERY

1 CERTIFIED HOME HEALTH
2 PRIV. PAY HOME HEALTH
3 OTHER HOME VISIT

A = [illegible] CHILD ALLOWANCE
B = [illegible]
E = EMPLOYEE DISCOUNT
C = COURTESY ALLOWANCE
T = BILLABLE THIRD PARTY

RETURN: 9/1/2/76
DATE
TO SEE: m.wife
FOR: UTI check.
REFERRED TO: ____

1 WALK-IN
[✓ 2 APPOINTMENT]
3 EMERGENCY
4 PRESCRIPTION, LAB OR X-RAY ONLY
5 RENTAL OR SUPPLY ONLY
6 NOT AT HOME
7 BROKEN APPT. / RE-APPT. ONLY

1 FAMILY PLANNING (KMC)
2 LOW / HIGH RISK MCH
3 EARLY & PERIODIC SCREENING (KMC)
4 FNS CHILD HEALTH
5 ANNUAL EMPL. PHYS.
9 OTHER ____ SPECIFY
[✓ 0 NOT APPLICABLE]

[✓ 1 NO REFERRAL]
2 INSIDE FNS
3 COUNTY AGENCY / FACILITY
4 REGIONAL AGENCY / FACILITY
5 STATE AGENCY / FACILITY
6 OTHER ____ SPECIFY

BILLING CODE
COMMENTS / INSTRUCTIONS

SIGNATURE Sallie Smith, R.N., FN.

[✓ ACUTE PROBLEM / TRAUMA]
ACUTE / TRAUMA FOLLOW-UP
CHRONIC, ROUTINE
CHRONIC, FLARE-UP
ASSESSMENT / PREVENTION

UTI	5 9 9 9	2
Normal Pregnancy	6 7 9 0	2

0 3 7

0 2

01 MD
02 PRIMARY CARE NURSE GRADUATE
03 FGN TRAINEE
04 RN
05 CRNA
06 LPN
07 AIDE / STUDENT NURSE
08 PHYSICAL THERAPIST
09 TECHNICIAN
10 PHARMACIST
11 SOCIAL WORKER
12 MEDICAL STUDENT
21 OTHER ____ SPECIFY

1 8

18 MEDICAL DIRECTIVES
19 PLAN OF CARE
20 MISST LINE

	PREVENTIVE	MAINTENANCE	CURATIVE
[✓ 01 HISTORY]	201	301	401
02 HX & PHYSICAL, COMPLETE	202	302	402
[✓ 03 VITAL SIGNS]	203	303	403
04 REVIEW & EXAM OF SYSTEMS, CONDITIONS (SEE CODES ON BACK)	204	304	404
60 05	265		460
05 DEVELOPMENTAL / CHILD CARE	205	305	405
06 PSYCHO / SOCIAL	206	306	406
07 PRE OP / PRE HOSPITAL CARE	207	307	407
08 POST OP / POST HOSPITAL CHECK	208	308	408
[✓ 09 USE OF MEDICATIONS]	209	309	[✓ 409]
HEALTH PRACTICES			
11 NUTRITION	211	311	411
[✓ 12 ELIMINATION]	212	312	[✓ 412]
13 SLEEP	213	313	413
[✓ 14 PHYSICAL ACTIVITY]	214	[✓ 314]	414
15 PERSONAL HYGIENE & GROOMING	215	315	415
16 FAMILY PLANNING	216	316	416
17 ENVIRONMENT	217	317	417
18 DRUG / ALCOHOL / TOBACCO USE	218	318	418
19 IMMUNIZATION	219	319	419
20 STRESS / GRIEF MANAGEMENT	220	320	420
21 INTERPERSONAL RELATIONS	221	321	421

01 SUTURE
02 SUTURE REMOVAL
03 WOUND CARE / DRESSING
04 FRACTURE / CAST CARE
  A. CAST APPLIED
  B. RECAST
  C. CAST REMOVED
  D. OTHER FRACTURE / CAST CARE
05 SPRAIN / DISLOCATION TREATMENT
06 MINOR SURGERY
07 ANESTHESIA, GENERAL
08 IVP DYE INJECTION
09 PROCTOSCOPY / SIGMOIDOSCOPY
10 EAR IRRIGATION
11 IUD INSERTION
12 IUD REMOVAL
13 ONCOLOGY THERAPY
14 OTHER SPECIAL PROCEDURES CPR, TRANSFUSION, OTHER SPECIFY ____
20 RESPIRATORY THERAPY
  A. POSTURAL DRAINAGE
  B. BREATHING EXERCISES
  C. I.P.P.B.
  D. OXYGEN THERAPY
21 PHYSICAL THERAPY
  A. P. & A. EXERCISE / R.O.M.
  B. ULTRASOUND
  C. WHIRLPOOL
  D. DIATHERMY
22 PERSONAL CARE
  A. BATH / BEDSIDE CARE
  B. GROOMING / NAIL CARE
  C. OTHER, SPECIFY ____
23 SKIN CARE
  A. THERAPEUTIC
  B. PREVENTIVE
  C. DECUBITI
  D. OTHER ULCERATIVE
24 ELIMINATION
  A. CATHETER / IRRIGATION
  B. ENEMA
  C. IMPACTION REMOVAL
25 NG TUBE
26 OTHER CARE, SPECIFY: ____
OTHER SERVICES
30 DELIVERY OF MED. SUPPLIES, MEDS
31 RESOURCE COORD. / ADMIN. PROC.
32 LONG DISTANCE TELEPHONE CALL FOR REFERRAL ____ LIST COST OF CALL
MEDICATIONS
[✓ 40 NEW MEDICATION, PREPACK]
41 MEDS REFILLED
42 NEW MEDS (RX) PRESCRIBED
43 PRESC (RX) RENEWED
44 MEDS ADM. (INJ., TOPICAL, ORAL, IV)
45 CONTINUE PRESENT MEDS ____ SPECIFY
46 ASPIRIN, OVER THE COUNTER DRUGS RECOMMENDED ____ SPECIFY

Hct	2	1	0
Dipstick	2	5	2
Micro UA	2	5	3
Ur Sept	1	0	2
B Form to			
H Lab +			
uisition slip			

01 – 1, 2, 3, 9 DPT 1, 2, 3, BOOSTER
02 – 1, 2, 9 D & T 1, 2, BOOSTER
03 – 1, 2, 9 TET. TOX 1, 2, BOOSTER
04 – 9 TET. ANTITOXIN
05 – 1, 2, 3, 9 POLIO - SABIN 1, 2, 3, BOOSTER
06 – 0 RUBELLA / RUBEOLA
07 – 1, 2, 9 [illegible] 1, 2, BOOSTER
08 – 0 [illegible] IMMUNIZATIONS

ITEM		QUANTITY	CHARGES	MED CODE	PAY SOURCE
Gantrisin	mg	44	4.64		Kmc
Pyridium	mg.	9	1.00		PP

468

ADDITIONAL SHOULD BE LISTED ON BACK OF PAGE

c: If sensitivity test is done extra $7.50 is ch

MARY BRECKENRIDGE HOSPITAL

CODE

36

NAME
jones, mary

RESPONSIBLE PARTY
Jones, Henry

ADDRESS
RT #5 Box 165

CITY, STATE, ZIP CODE
Hyden, Ky.

BIRTHDATE
02-08-47

MEDICARE NO.

MED. RECORD NO.
64-0007

HOUSEHOLD NO.
64-0008

COUNTY
066

SEX RACE MAR. STATUS
2 1 2

LOC
1

OTHER INSURANCE NO. AND INFORMATION
Kmc
61-02-37929 373

DATES
CERT. ______
RECERT. ______
HOSP. ADM. ______
HOSP. DIS. ______

1 ROUTINE INITIAL
[✓ 2 ROUTINE FOLLOW-UP]
3 EXTENSIVE INITIAL
4 EXTENSIVE FOLLOW-UP
5 BRIEF FOLLOW UP
6 OUTSIDE REGULAR HOURS
7 ADDITIONAL PERSON / BRIEF CHECK
8 HEALTH PROMOTION WITH NO CARE
9 HEALTH PROMOTION WITH CARE

[✓ 1 KMC]
2 MEDICARE PT. A
3 MEDICARE PT. B
4 WORKMEN'S COMP.
5 BC / BS
6 OTHER INS.
[✓ 7 CASH / PRIVATE PAY]
8 S.L.U.
9 EMPLOYEE
0 OTHER

MD CLINIC VISIT ( )			
MD HOME VISIT ( )			
NURSE CLINIC VISIT	5	00	1
NURSE HOME VISIT			31
DRUGS & SOLUTIONS	2	00	250
E.K.G.			200
EMERGENCY ROOM			500
INHALATION THERAPY			100
LABORATORY			30
OPERATING ROOM			100
PHYSICAL THERAPY			450
SPECIAL PROCEDURES			550
SUPPLIES, ETC.			250
X RAY			150
ANESTHESIA			600
RENTALS			650
SOCIAL SERVICE			700
TRANSPORTATION			750
TOTAL CHARGES →	7	00	
PAID TODAY	5	00	1
ALLOWANCE ( )			
BALANCE LEFT	2	00	▨

DISTRICTS:
PATIENT HOME
NURSE CLINIC
SPECIAL CLINIC ______ SPECIFY
SIDE OF ROAD, OTHER
HOSPITAL:
GENERAL CLINIC
[✓ MTO CLINIC]
PEDS CLINIC
GYN CLINIC
HEALTH ASSESSMENT CLINIC
ORTHOPEDIC CLINIC
NEUROLOGY CLINIC
OPHTHALMOLOGY CLINIC
OTHER SPECIAL CLINIC ______ SPECIFY
EMERGENCY ROOM
OTHER:
SOCIAL SERVICE
TRANSPORTATION MILEAGE ______

1 WELL CHILD / ADULT
2 MEDICAL
3 SURGICAL / ORTHOPEDIC
4 GYN
[✓ 5 PRENATAL]
6 POSTPARTAL
7 NEONATAL
8 FAMILY PLANNING
9 PSYCHO / SOCIAL
0 OTHER SPECIALTY ______

[✓ 1 INDIVIDUAL]
2 FAMILY
3 ANIMAL

1 NEW
2 OLD
[✓ 3 REG. FOR MIDWIFERY]

1 CERTIFIED HOME HEALTH
2 PRIV. PAY HOME HEALTH
3 OTHER HOME VISIT

A BILL CHILD ALLOWANCE
B MIDWIFERY
C EMPLOYEE DISCOUNT
C COURTESY ALLOWANCE
F BILLABLE THIRD PARTY

RETURN: 4-1-76 DATE
TO SEE: ______
FOR: check.
REFERRED TO: Dr. Gilbert

1 WALK-IN
2 APPOINTMENT
3 EMERGENCY
4 PRESCRIPTION, LAB OR X-RAY ONLY
5 RENTAL OR SUPPLY ONLY
6 NOT AT HOME
7 BROKEN APPT. / RE APPT. ONLY

1 FAMILY PLANNING (KMC)
[✓ 2 LOW / HIGH RISK MCH]
3 EARLY & PERIODIC SCREENING (KMC)
4 FNS CHILD HEALTH
5 ANNUAL EMPL. PHYS.
9 OTHER ______ SPECIFY
0 NOT APPLICABLE

[✓ 1 NO REFERRAL]
2 INSIDE FNS
3 COUNTY AGENCY / FACILITY
4 REGIONAL AGENCY / FACILITY
5 STATE AGENCY / FACILITY
6 OTHER ______ SPECIFY

BILLING CODE

COMMENTS / INSTRUCTIONS

SIGNATURE ______ TITLE CNM

ACUTE PROBLEM / TRAUMA
ACUTE / TRAUMA FOLLOW UP
CHRONIC, ROUTINE
CHRONIC, FLARE UP
[✓ ASSESSMENT / PREVENTION]

Normal Pregnancy	6	7	9	0	2
Living Problems	9	0	5	C	2

	2	4

0	2

01 MD
02 PRIMARY CARE NURSE GRADUATE
03 PCN TRAINEE
04 RN
05 CRNA
06 LPN
07 AIDE / STUDENT NURSE
08 PHYSICAL THERAPIST
09 TECHNICIAN
10 PHARMACIST
11 SOCIAL WORKER
12 MEDICAL STUDENT
21 OTHER ______ SPECIFY

SKILL CODE

1	8

18 MEDICAL DIRECTIVES
19 PLAN OF CARE
20 MILESTONE

	PREVENTIVE	MAINTENANCE	CURATIVE
[✓ 01 HISTORY.]	[✓ 201]	301	401
02 HX & PHYSICAL, COMPLETE	202	302	402
[✓ 03 VITAL SIGNS]	203	303	403
04 REVIEW & EXAM OF SYSTEMS, CONDITIONS (SEE CODES ON BACK)	204	304	404
64 66	264		
05 DEVELOPMENTAL / CHILD CARE	205	305	405
06 PSYCHO / SOCIAL	206	306	406
07 PRE OP / PRE HOSPITAL CARE	207	307	407
08 POST OP / POST HOSPITAL CHECK	208	308	408
[✓ 09 USE OF MEDICATIONS]	209	309	409
HEALTH PRACTICES			
[✓ 11 NUTRITION]	[✓ 211]	311	411
[✓ 12 ELIMINATION]	212	312	412
[✓ 13 SLEEP]	213	313	413
[✓ 14 PHYSICAL ACTIVITY]	[✓ 214]	314	414
15 PERSONAL HYGIENE & GROOMING	215	315	415
[✓ 16 FAMILY PLANNING]	216	316	416
17 ENVIRONMENT	217	317	417
18 DRUG / ALCOHOL / TOBACCO USE	218	318	418
19 IMMUNIZATION	219	319	419
20 STRESS / GRIEF MANAGEMENT	220	320	420
[✓ 21 INTERPERSONAL RELATIONS]	[✓ 221]	321	421

01 SUTURE
02 SUTURE REMOVAL
03 WOUND CARE / DRESSING
04 FRACTURE / CAST CARE
  A. CAST APPLIED
  B. RECAST
  C. CAST REMOVED
  D. OTHER FRACTURE / CAST CARE
05 SPRAIN / DISLOCATION TREATMENT
06 MINOR SURGERY
07 ANESTHESIA, GENERAL
08 IVP DYE INJECTION
09 PROCTOSCOPY / SIGMOIDOSCOPY
10 EAR IRRIGATION
11 IUD INSERTION
12 IUD REMOVAL
13 ONCOLOGY THERAPY
14 OTHER SPECIAL PROCEDURES CPR, TRANSFUSION, OTHER SPECIFY Pelvic
20 RESPIRATORY THERAPY
  A. POSTURAL DRAINAGE
  B. BREATHING EXERCISES
  C. I.P.P.B.
  D. OXYGEN THERAPY
21 PHYSICAL THERAPY
  A. P & A EXERCISE / R.O.M.
  B. ULTRASOUND
  C. WHIRLPOOL
  D. DIATHERMY

22 PERSONAL CARE
  A. BATH / BEDSIDE CARE
  B. GROOMING / NAIL CARE
  C. OTHER, SPECIFY ______
23 SKIN CARE
  A. THERAPEUTIC
  B. PREVENTIVE
  C. DECUBITI
  D. OTHER ULCERATIVE
24 ELIMINATION
  A. CATHETER / IRRIGATION
  B. ENEMA
  C. IMPACTION REMOVAL
25 NG TUBE
26 OTHER CARE, SPECIFY: ______
OTHER SERVICES
30 DELIVERY OF MED. SUPPLIES, MEDS
31 RESOURCE COORD. / ADMIN. PROC.
32 LONG DISTANCE TELEPHONE CALL FOR REFERRAL: ______ LIST COST OF CALL
MEDICATIONS
40 NEW MEDICATION PREPACK
41 MEDS REFILLED
42 NEW MEDS (RX) PRESCRIBED
43 PRESC (RX) RENEWED
44 MEDS ADM. (INJ., TOPICAL, ORAL, IV)
45 CONTINUE PRESENT MEDS ______ SPECIFY
46 ASPIRIN, OVER THE COUNTER DRUGS RECOMMENDED ______ SPECIFY

C	7	9

01 – 1, 2, 3, 9 DPT 1, 2, 3, BOOSTER
02 – 1, 2, 9 D & T 1, 2, BOOSTER
03 – 1, 2, 9 TET. TOX 1, 2, BOOSTER
04 – 0 TET. ANTITOXIN
05 – 1, 2, 3, 9 POLIO SABIN 1, 2, 3, BOOSTER
06 – 0 RUBELLA / RUBEOLA
[✓ 07] – 1, 2, 9 FLU SHOT 1, 2, BOOSTER
08 – 0 IMMUNIZATIONS

ITEM	QUANTITY	CHARGES	MED CODE	PAY SOURCE
Routine Pren. Vits	.32	Rx		
484 Fluogen .5cc	1	2.00		07

ADDITIONAL SHOULD BE LISTED ON BACK OF PAGE

SAMPLE D-MARY BRECKENRIDGE HOSPITAL

S:

28023

CIRCLE OR FILL OUT ALL APPROPRIATE CODES
PRESS HARD YOU ARE MAKING 4 COPIES

FRONTIER NURSING SERVICE ENCOUNTER FORM

12-039-93

SERIAL NO. D 48479

ID CARD SITE 10 (CODE) DATE 11-10-76

CODE

Jones, Susan 67-2567

Harry 07191

Wendover, Ky 41775

02-04-27 212 1

CeRT

OTHER INSURANCE NO. AND INFORMATION

SLU(copy card)

attach To E-Form

DATES
CERT. ______
RECERT. ______
HOSP. ADM. ______

[✓ 1 ROUTINE INITIAL]
2 ROUTINE FOLLOW-UP
3 EXTENSIVE INITIAL
4 EXTENSIVE FOLLOW-UP
5 BRIEF FOLLOW-UP
6 OUTSIDE REGULAR HOURS
7 ADDITIONAL PERSON / BRIEF CHECK
8 HEALTH PROMOTION WITH NO CARE
9 HEALTH PROMOTION WITH CARE

1 KMC
2 MEDICARE PT A
3 MEDICARE PT B
4 WORKMEN'S COMP
5 BC / BS
6 OTHER INS.
7 CASH / PRIVATE PAY
[✓ 8 S.L.U.]
EMPLOYEE
0 OTHER

CHARGES

NO CLINIC VISIT ( )		
NO HOME VISIT ( )		
NURSE CLINIC VISIT	5	00
NURSE HOME VISIT		
DRUGS & SOLUTIONS		
EKG		
EMERGENCY ROOM		
INHALATION THERAPY		
LABORATORY	26	50
OPERATING ROOM		
PHYSICAL THERAPY		
SPECIAL PROCEDURES		
SUPPLIES, ETC.		
X-RAY		
ANESTHESIA		
RENTALS		
SOCIAL SERVICE		
TRANSPORTATION		
TOTAL CHARGES	31	50
PAID TODAY		
ALLOWANCE ( )		
BALANCE LEFT		

COMMENTS / INSTRUCTIONS

Name + Title, RN

SIGNATURE

DISTRICTS
10 PATIENT HOME
11 NURSE CLINIC
12 SPECIAL CLINIC ______ SPECIFY
13 SIDE OF ROAD OTHER
20 HOSPITAL
[✓ 20 GENERAL CLINIC]
21 MFB CLINIC
22 PEDS CLINIC
23 GYN CLINIC
24 HEALTH ASSESSMENT CLINIC
25 ORTHOPEDIC CLINIC
26 NEUROLOGY CLINIC
27 OPHTHALMOLOGY CLINIC
28 OTHER SPECIAL CLINIC ______ SPECIFY
30 EMERGENCY ROOM
OTHER:
40 SOCIAL SERVICE
41 TRANSPORTATION MILEAGE ______

1 WELL CHILD / ADULT
[✓ 2 MEDICAL]
3 SURGICAL / ORTHOPEDIC
4 GYN
5 PRENATAL
6 POSTNATAL
7 NEONATAL
8 FAMILY PLANNING
9 PSYCHO / SOCIAL
0 OTHER SPECIALTY ______

[✓ 1 WALK IN]
2 APPOINTMENT
3 EMERGENCY
4 PRESCRIPTION, LAB OR X-RAY ONLY
5 DENTAL OR SUPPLY ONLY
6 NOT AT HOME
7 BROKEN APPT. / RE APPT. ONLY

1 INDIVIDUAL
[✓ 2 FAMILY]
3 ANNUAL

1 NEW
[✓ 2 OLD]
3 REG. FOR MIDWIFERY

1 CERTIFIED HOME HEALTH
2 PRIV. PAY HOME HEALTH
3 OTHER HOME VISIT

1 FAMILY PLANNING (KMC)
2 LOW / HIGH RISK MCH
3 EARLY & PERIODIC SCREENING (KMC)
4 FNS CHILD HEALTH
5 ANNUAL EMPL. PHYS.
6 OTHER ______ SPECIFY
[✓ 0 NOT APPLICABLE]

RETURN 11-17-76
TO SEE ~~A~~ FNP
FOR Check
REFERRED TO: ______

[✓ 1 NO REFERRAL]
2 INSIDE FNS
3 COUNTY AGENCY / FACILITY
4 REGIONAL AGENCY / FACILITY
5 STATE AGENCY / FACILITY
6 OTHER ______

[✓ 1 ACUTE PROBLEM / TRAUMA]
2 ACUTE / TRAUMA FOLLOW-UP
3 CHRONIC, ROUTINE
4 CHRONIC, FLARE-UP
5 ASSESSMENT / PREVENTION

viral gastroent	0099	2	341	07
pharyngitis	4620	1	211	01

01 PRIMARY CARE NURSE GRADUATE
02 FCN TRAINEE
03 RN
05 CNRA
06 LPN
07 AIDE / STUDENT NURSE
08 PHYSICAL THERAPIST
09 TECHNICIAN
10 PHARMACIST
11 SOCIAL WORKER
12 MEDICAL STUDENT
21 OTHER ______

13

18 MEDICAL DIRECTIVES
19 PLAN OF CARE

01 HISTORY	201	301	401
02 HX & PHYSICAL COMPLETE	202	302	402
[✓ 03] VITAL SIGNS	203	303	403
[✓ 04] REVIEW & EXAM OF SYSTEMS CONDITIONS (SEE CODES ON BACK)	204	304	404
53 55 59			453 459
05 DEVELOPMENTAL, CHILD CARE	205	305	405
06 PSYCHO / SOCIAL	206	306	406
07 PRE OP, PRE HOSPITAL CARE	207	307	407
08 POST OP, POST HOSPITAL CHECK	208	308	408
[✓ 10] LIST OF MEDICATIONS	209	309	[✓ 409]
HEALTH PRACTICES			
[✓ 11] NUTRITION	211	311	[✓ 411]
12 ELIMINATION	212	312	412
13 SLEEP	213	313	413
14 PHYSICAL ACTIVITY	214	314	414
[✓ 15] PERSONAL HYGIENE & GROOMING	[✓ 215]	315	415
16 FAMILY PLANNING	216	316	416
[✓ 17] ENVIRONMENT	217	317	417
[✓ 18] DRUG, ALCOHOL / TOBACCO USE	218	318	418
19 IMMUNIZATION	219	319	419
20 STRESS, GRIEF MANAGEMENT	220	320	420

01 SUTURE
02 SUTURE REMOVAL
03 WOUND CARE / DRESSING
04 FRACTURE / CAST CARE
- A. CAST APPLIED
- B. RECAST
- C. CAST REMOVED
- D. OTHER FRACTURE / CAST CARE

05 SPRAIN / DISLOCATION TREATMENT
06 MINOR SURGERY
07 ANESTHESIA, GENERAL
08 IV / PO / IM INJECTION
09 PROCTOSCOPY / SIGMOIDOSCOPY
10 EAR IRRIGATION
11 IUD INSERTION
12 IUD REMOVAL
13 ONCOLOGY THERAPY
14 OTHER SPECIAL PROCEDURES CPR, TRANSFUSION, OTHER SPECIFY ______
20 RESPIRATORY THERAPY
- A. POSTURAL DRAINAGE
- B. BREATHING EXERCISES
- C. IPPB
- D. OXYGEN THERAPY

21 PHYSICAL THERAPY
- A. P & A EXERCISE - ROM
- B. ULTRASOUND
- C. WHIRLPOOL
- D. DIATHERMY

22 PERSONAL CARE
- A. BATH / BEDSIDE CARE
- B. GROOMING / NAIL CARE
- C. OTHER, SPECIFY ______

23 SKIN CARE
- A. THERAPEUTIC
- B. PREVENTIVE
- C. DECUBITI
- D. OTHER ULCERATIVE

24 ELIMINATION
- A. CATHETER / IRRIGATION
- B. ENEMA
- C. IMPACTION REMOVAL

25 NG TUBE
26 OTHER CARE, SPECIFY ______

OTHER SERVICES
30 DELIVERY OF MED. SUPPLIES, MEDS
31 RESOURCE COORD. - ADMIN. PROC.
32 LONG DISTANCE TELEPHONE CALL FOR REFERRAL ______ LIST COST OF CALL

MEDICATIONS
40 NEW MEDICATION PREPACK
41 MEDS REFILLED
42 NEW MEDS (RX) PRESCRIBED
43 PRESC (RX) RENEWED
44 MEDS ADM (IM, TOPICAL, ORAL, IV)
45 CONTINUE PRESENT MEDS ______
46 ASPIRIN, OVER THE COUNTER DRUGS RECOMMENDED Sw... SPECIFY

Hemocount	2	0	0
Stool culture	7	5	0
Strep Screen	3	0	0
CBC	7	0	0

01 - 1, 2, 3, 9 DPT 1, 2, 3 BOOSTER
02 - 1, 2, 9 DT 1, 2, BOOSTER
03 - 1, 2, 9 TET TOX 1, 2 BOOSTER
04 - 0 TET ANTITOXIN
05 - 1, 2, 3, 9 POLIO, SABIN 1, 2, 3 BOOSTER
06 - 0 RUBELLA / RUBEOLA
07 - 1, 2, 9 FLU SHOT 1, 2 BOOSTER
08 - 0 OTHER IMMUNIZATIONS

ITEM	QUANTITY	CHARGES		

FEE SCHEDULE

II.

	Home	Clinic
1. Routine initial	$10	$4
2. Routine followup	5	3
3. Extensive initial	--	6
4. Extensive followup	6	5
5. Brief followup	3	2
6. Outside regular hours	10	7
7. Additional person/brief check	2	2
8. Health Promotion	0	0
9. Health Promotion with care	3	3

1. Routine initial. Initial visit to a patient in the home or in the clinic for each new spell of illness. Appropriate history and physical examination, diagnosis, and initiation of treatment.
2. ROutine followup. Followup visit to determine the course of the illness, including partial history and physical, evaluation of effectiveness of medication.
3. Extensive initial. Clinic only. A thorough history and physical and initiation of treatment if indicated.
4. Extensive followup. A prolonged visit requiring much nursing skill; intravenous, n.g. tube care, dressing changes, etc.
5. Brief followup. A brief stop or clinic visit to refill meds, pick up supplies, etc., with a brief encounter with the patient.
6. Outside regular hours, Sundays or Holidays.
7. Additional person/brief check. Besides the primary patient, one who is treated at the same visit.
8. Health Promotion. A drop-in visit not requested by a member of the household with no service rendered remains a free visit. An encounter form must be filled out but with nothing in the CHARGE section. This is FNS policy and the cost is absorbed by the administration.
9. Health Promotion with care. A drop-in visit in which the nurse is requested during her visit to check one or more members of the family BRIEFLY.

Strep-screening a family when necessary will be considered a routine followup and the full charge will be $3.00 for the whole family. An individual followup strep screen is $2.00.

Well Child Clinic. No charge to the patient for the well child, to age 6. The sick child changes status to Health Promotion with Care or the appropriate category above. The encounter form for the well child must be filled out in the CHARGE section as follows: Nurse visit, W-$3.00; Laboratory, W-(the amount of the charges). The administration absorbs the charges.

There will be no charge for picking up meds or supplies at the clinic or dropping them off at the home (if necessary)-if there is no patient encounter. Encounter form will show "5" as status of visit and "30" under General "Treatment and Services". Drugs and supplies should be entered in the proper section.

Chas L Thornbury

February 7, 1975

Charles Thornbury

Effective as of 11 .6.

3 pages removed because of illegibility:
"District Orientation Only"
"FNS Diagnostic List"
"FNS Reference Sheet"

DEFINITION OF TERMS:

The following words appear in sections of the Encounter Form, at the FNS their meanings are as follows:

Assessment - review and evaluation of a patient's physical, emotional, and social situation which provides basic information essential for:

1) Detection of early warning signs for potential medical problems.
2) Formulating plans for management of what therapeutic or preventive procedures need to be continued or stopped.

Counseling & Instruction - Refers to any teaching or counseling (corrective or supportive) undertaken during encounter.

1) Preventive - explanations, conversations, or direct demonstration that contributes to prevention of adverse conditions or practices that affect a person's physical and social environment. This in turn affects a person's physical, mental, and social well being (this includes women in the prenatal category). Preventive is essentially primary prevention.
2) Maintenance - any teaching that informs a person about what they can do to keep a stable condition, or what they can do to keep from becoming worse. (Maintenance is essentially secondary prevention.) To do maintenance counseling a person must have a diagnosed problem.

3) Curative - (therapeutic) any teaching that is directed to alter a person's illness state and improvement of their condition. This also refers to terminally ill patients where counsel relates to practices or procedures that would alleviate pain, stress or grief.

4) Developmental/Child Care - A child's mental, social, physical development and growth. An essential component of a well-child check.

5) Psycho-social - mental or social disorders which affect a persons ability to function effectively. (Refers primarily to a diagnosed mental-social condition), e.g. depression, anxiety, schizophrenia, retardation, juvenile delinquency, child abuse, truancy. Any condition in which dysfunction is identified.

6) Stress and Grief Management - refers to acute stress or crises situation such as job pressure or loss of job, entering school, death in family; refers to any condition in which problems in coping with developmental or situational stress which is anticipated or identified

7) Interpersonal Communication - difficulty in relating to individuals or specific groups, e.g. family members, people at job. This may include child discipline, marital relations, participation in community planning.

Emergency Room - any unscheduled visit (including outside of clinic hours) to the Mary Breckinridge Hospital Emergency Room. This is to be circled whether care is provided by a physician, nurse, or aide.

Health Practices - any personal activity that pertains to an individual's physical, mental, social condition; and which contributes to or impairs their functional ability.

Health Promotion - refers to any health teaching or counseling (primarily preventive) that a practitioner would undertake with an individual and a family. The purpose of health promotion is to contribute to understanding about a person's state of health or illness.

Medication - any drug, (prescription or non-prescription), or supplies that are used for treatment purposes. Pre-pack meds, refers to any medication premeasured and prepacked at the FNS pharmacy.

Referral - a referral means that arrangements are to be made for a patient to receive services from another type of speciality practitioner, e.g. physical therapist, surgeon, dentist, or speciality clinic, District to MBH.

Reimbursement - From third party to FNS for providing a specific service. Amount received is not always the same as amount charged.

Rentals - any durable item used by patients in home, (there is a monthly billing procedure), e.g. wheel chair, hospital bed.

Solutions - items which come from Central Purchasing or Pharmacy, e.g. irrigating solutions, saline. Brand name of solution must be specified.

Supplies - items that are requisitioned or dispensed and come from Central Purchasing office at the MBH, e.g. bandages, cotton. (This could include solutions.)

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MEANINGFUL AUDIT FOR SERVICE-BASED VERSUS CREDENTIAL-BASED REIMBURSEMENT

Introduction:

An essential component in establishing service-based reimbursement is the method and tools for formally auditing and evaluating services. Audit procedures help answer questions about reliability, validity and quality of data, its analysis, and the overall clinical performance in services rendered at the FNS.

We are concerned with four basic elements in a practitioner's performance. These are:

1) Thoroughness (in data gathering about a patient's problem and in in management procedures);

2) Logic or analytic skill in evaluating patient's condition(s) and providing appropriate management techniques;

3) Efficiency both in time spent for patient encounters, and in quantity and quality of resources used;

4) Reliability both in diagnostic and management decision-making. Reliability is essential in order to validate and generalize the organization of services and use of types of practitioners.

This has further implications for demonstrating the validity of service-based reimbursement.

In the interests of providing optimal service to the population served by the FNS, an effective evaluation system is being designed. Although implementation of the problem oriented system and evaluation antedates this proposal, there is new impetus for designing an audit system that addresses demonstration of service-based reimbursement. The audit and evaluation design must cover the entire FNS system. Our approach follows the reasoning and organization of the problem oriented record system as developed by Dr. Lawrence Weed, and which is currently in use at the FNS.

This approach is based on the premises that:

1) All data and management procedures must be associated with a specific problem.
2) Data on a problem can be easily retrieved from the medical record.

Basis For Audit:

The conceptual basis of the audit system follows the approach of the Problem Oriented Medical Record which can be divided into four decision-making steps:

1) To collect information
2) To decide what is wrong
3) To assess what to do
4) To follow through on decided plans

The four major areas on which audit will be based are:

1) Data Base - patient's history, physical exam, laboratory procedures.
2) The Problem List - as defined according to data (subjective, e.g. patient's chief complaint and objective) as defined according to practitioner's level of understanding.
3) The Plan - goals and plans for action which will include request for additional data, treatment and contingency plans.
4) The Progress Notes - written in SOAP format, symptomatic as presented by patient, objective physical exam, lab tests; assessment, evaluation by practitioner; plans for follow-up treatment, medications, education, plans for further diagnostic work-up and treatment.

In short, all plans for management and progress are identified according to a specified problem. Thus the audit system is problem oriented rather than being based on resources used (e.g. lab tests, x-ray, medications, personnel). Resource use is evaluated according to problems presented in the problem list.

Establishing Standards of Care:

A major goal in the audit procedure is to determine what critical parameters are established for a given problem. The FNS Medical Directives will be used in developing guidelines for what is expected in management of specific problems encountered in outpatient service. The protocols for management as stated in the Medical Directives need to be reviewed and integrated into an outline of expected standards of care. The medical staff at the FNS will be responsible for developing this aspect.

A second important element in establishing standards of care is through improvement of how medical data is recorded. In the problem oriented system this includes expanding the use of flow sheets as a part of the patient record. Since some patients, especially those with multiple chronic problems, have a considerable volume of data in their charts, it is important that much of the data are streamlined and condensed into flow sheets. If a patient has a specific set of problems such as diabetes and hypertension, a separate flow sheet designed for each problem will be used. This approach is important in assurance of continuity of care especially when there is more than one practitioner involved in patient management, and clinic visits may take place both in the Mary Breckinridge Hospital and at the District Clinics.

Selection of Audit Topics:

A method for obtaining information about the effectiveness of ambulatory medical services, is the tracer disease approach. Focus on a tracer disease gives a structural approach to looking at how well clinical services are responding to needs of an identified population. If expected standards of care are not being followed e.g. for management of diabetics, one can expect a deterioration of diabetes related conditions and a progression of a diabetic's functional disabilities.

Selection of a tracer disease, as an audit topic, should follow certain criteria. Among the most significant, suggested by Kessner and Kalk, are:

1) A problem, disease, or procedure should have a significant functional impact;

2) A problem should be relatively well defined and easy to diagnose in practice settings;

3) The natural history of the condition should vary with utilization and effectiveness of medical care;

4) The techniques of medical management of the condition should be well defined for at least one of the following processes: prevention, diagnosis, treatment, or rehabilitation.

On a broader level, all charts reviewed according to a specific disease category e.g. diabetes, will also be reviewed collectively for completeness, and reliability. This review will cover such categories as:

1) Completeness of history and physical exams;

2) Appropriate timing and completeness of screening procedures;

3) Accuracy of lab findings;

4) Appropriate medical action as stated in plans;

5) Updated problem lists.

Who Will Audit:

Audit procedures can be carried out by practitioners qualified to review a broad spectrum of problems encountered in ambulatory medical care settings. If charts are audited according to a specific disease entity, then practitioners should be qualified to review charts in their specialty areas. The problem-oriented framework for auditing, and expected performance standards are to be explicitly stated. Plans call for one nurse practitioner and one physician to undertake a general audit of 50 randomly selected records.

Summary:

The problem oriented system provides a systematic approach to reviewing the organization of services, use of resources, and practitioners' competency in handling medical problems. The overall prupose of the audit system is to assess qualtiy of care through a systematic and periodic assessment of practitioners' thoroughness, reliability, analytic sense and efficiency. This has further implications for assessing quality of care through outcome studies, that is, the identification of the outcome or level of functional ability of a person after they have received certain types of service. Audit of practitioners' performance has direct bearing on the level of quality service that a primary care institution, such as the FNS, is able to provide.

Karen A. Gordon, M.P.H.
Frontier Nursing Service
October 1976

Ira Moscovice

ABSTRACT

Development of a Method for the Analysis of the Utilization of Resources in an Ambulatory Care Setting

Doctoral Dissertation, Yale University, May, 1976

The major objective of this research is to develop a methodological framework which will facilitate the analysis of resource utilization in primary care environments. Specific emphasis will be placed on trying to understand reasons for variation in treatment patterns. The intent is not to develop a framework specific to a particular study setting but rather to try to understand the elements necessary in a framework that will allow the monitoring and description of primary care treatment patterns on a routine basis.

The major components of the model underlying this research that are presumed to affect primary care treatment patterns are:

1. characteristics of the patient (e.g., age, sex);
2. characteristics of the medical problem being treated (e.g., existence of comorbidities);
3. characteristics of the delivery system (e.g., type of provider, type of delivery setting).

Important methodological considerations include:

1. the selection of a set of tracer conditions appropriate for evaluating the interaction effects of the variables being considered;
2. the development of problem specific computerized algorithms for combining patient visit information into episodes of care;
3. the selection of appropriate measures of utilization.

The Frontier Nursing Service (FNS) was used as a study setting. FNS is a primary health care service and training center headquartered in Leslie County of eastern Kentucky, an area that covers 1,000 square miles with a population of approximately 15,000.

FNS currently operates a forty-bed hospital with outpatient facilities, seven district nursing outposts, and an administrative headquarters. The FNS staff, as of January 1, 1975, included four physicians and forty-two nursing personnel (e.g., nurse midwives, family nurse practitioners, registered nurses). Hence, the nurse, rather than the physician forms the core of the service.

Over the past three years, FNS has collected information on the outpatient visits of its patients through the use of an encounter form. An encounter form is filled out for each outpatient visit at FNS made either at the hospital clinics, the hospital emergency room, the district outposts, or the patient's home.

This research used the encounter information collected by FNS for the year 1974. This constitutes information on 57,954 outpatient encounters and was sent to this researcher in the form of computer tapes.

The first stage analysis is comprised of a multivariate contingency table analysis that tests simple hypotheses and indicates the proper selection of variables for inclusion in the second stage analyses.

The second-stage analyses use an interactive data analysis system, AUTOGRP, to perform a stepwise, nonsymmetrical branching technique based on variance reduction which yields insight into higher-order interaction effects. AUTOGRP offers a simple clustering alternative to linear regression.

Results from the first stage analyses indicate that variation in treatment patterns was significantly affected by the nature of the delivery setting for the two acute, self limiting problems of otitis media and tonsillitis/pharyngitis. However, variation in treatment patterns was significantly affected by the skill level of the provider for the acute/chronic condition, urinary tract infection.

Results from the second stage analyses indicate that:

1.a. for otitis media and tonsillitis/pharyngitis, variation in the use of medication was primarily affected by the nature of the delivery setting;

b. for urinary tract infection, variation in the use of medication was primarily affected by the nature of the delivery setting and the skill level of the provider;

2.a. for otitis media and tonsillitis/pharyngitis, variation in the use of laboratory tests was primarily affected by the nature of diagnosed medical comorbidities and the nature of the delivery setting;

b. for urinary tract infection, variation in the use of laboratory tests was primarily affected by the skill level of the provider and the nature of the delivery setting;

3. for all three problems, variation in follow-up visits was primarily affected by the skill level of the provider.

Evaluation of the use of an encounter form as a source of information is also considered. It was concluded that a well-designed encounter form is virtually as valid a source as the medical record when analyzing resource use in a primary care environment. Uses of the FNS encounter form for accounting, planning, and research purposes are documented.

Future work is envisaged in the following two areas:

1. testing of the feasibility of developing a system for patient care appraisal in a primary care setting;
2. analysis of the impact and cost-effectiveness of a preventive-oriented primary health care system.

APPENDIX L

AMERICAN NURSES' ASSOCIATION
NATIONAL REVIEW COMMITTEE

Site Team Report

Fronteir School of Midwifery and Family Nursing
Fronteir Nursing Services, Inc.
Hyden, Leslie County, Kentucky

Director
Gertrude Isaacs

Site Team Members:

Catherine De Angelis, M.D., Chairperso
Margaret Jones, M.S.N., R.N.
Joan Mulligan, Ph.D., R.N.

Date of Visit:

February 3 and 4, 1977

PHILOSOPHY

The orgin of the program, in 1925, was strickly based in nursing. The addition of physicians, social workers, health educators, etc. came much later. These para-nursing professionals augment the nursing model well.

The role of the consumer is emphasized as evident by the following passage from the written (and practiced) philosophy: "Self-care, likewise, is best learned by the individuals/families when the health care provider performs as a role model for the population served, with the expectation that the consumer assume appropriate responsibility for their own care."

The commitment to continuing education for faculty and students is exemplified by (1) stipends are available for faculty to accuire the next highest degree, (2) exchange programs between faculty members of other institutions, (3) numerous seminars and workshops sponsored by the University of Kentucky, (4) telephone conferences conducted by the University of Kentucky and (5) faculty and students are sent to regional and national meetings.

STUDENTS

The admission's criteria and selection of students are based on clearly defined criteria. The pre-admission and guidance program includes a full month orientation program. The students have ready access to reasonable housing and excellent health services. $22,000.00 was spent in 1975-76 on student financial aid. A newly-formed student council provides a mechanism for grievances but this mechanism is not stated in writing. Students interview candidates but do not serve on the admission committee. There is no specific appeals committee.

FINANCES

A budget of $196,505.00 (1975-76) provides sufficient funds to meet program objectives. Long range financial planning includes an application for a three-year NIH grant to begin in the fall of 1977. However, sufficient funds will be available from the service component to assure continuation of the program if the grant is not funded.

If direct third party reinbursement to the nurses were possible in the service component, the program would not have hired as many physicians or started a home care component of the program.

INSTITUTIONAL SUPPORT

The Fronteir Nursing Service, Inc. provides adequate classroom, clinical, library and office space and facilities. In return for this, 8% of grant monies is paid to the FNS hospital. Joint appointments for faculty and/or support services are received from the University of Kentucky, Vanderbilt University, Eastern Kentucky University, Cincinnati Childrens Hospital and Hazard Community College.

Standard technical records and an in-progress record containing relevant academic progress are used to advise students on an individual needs basis.

However, their basic objective is to safeguard the lives and health of individuals in rural areas where there is inadequate medical service. The data from their catchment area very impressively shows that they have achieved the major objective. They have significantly altered the curriculum over the past few years to meet the demands of students and faculty to keep abreast of modern teaching methodologies. Internal and external audits are performed to moniter all aspects of the program.

There have been 140 graduates of the modern program since September, 1970. Of these, 82% have accepted rural primary care assignments, 9% are employed in urban primary care settings and 4% are in non-primary care settings. Twenty percent of their students are practicing in other countries. Many of their graduates are enrolled in or have completed their next highest degree.

The program has generated 15 to 20 papers which have been presented and/or published in regional and national meetings and journals. A number of studies are currently being conducted and others have been planned for the future.

SUMMARY:

It would be possible to go on for pages describing the virtues of the program. However, let it suffice to say that it is extremely impressive.

CONCERNS:

There appear to be some fragmentation between the Family Nurse (FN) and Certified Nurse Midwife (CNM) components of the program. This may be the result of having added a strong F.N. component to part of a strong CNM component with a long history of excellent service. We would hope that faculty, staff and students would work towards a greater cohesiveness of the unified program.

While the pediatric component certainly meets the standards of the ANA, it is blatantly weaker than the excellent Adult and Ante/Post Partal Components.

There are no students on the admissions committee

There is no specific appeals committee or written mechanism for student appeal.

STRENGTHS:

The FNS is an extremely effective and efficient health care educational and service faculty (i.e., a network including hospitalized and have based clients) based totally on the nursing model.

The esprit de corps between faculty, staff and students.